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SCHIZOPHRENIA AND THE INEVITABILITY OF DEATH*

BY HAROLD F. SEARLES, M.D.

... throughout life one must learn to die.
SENECA

The first half of this paper** will be devoted to a hypothesis concerning schizophrenia: Among the many sources of anxiety against which the illness-system serves as a defense—some of these being unique to the patient's own particular existence, some of them uncommon, and some of them common to all mankind (that is, existential in nature)—is the seemingly prosaic, existential fact of the inevitability of death. Here the role, in schizophrenia, of this one form of existential anxiety† will be studied.

In the second half of the paper the focus of the discussion will be expanded to explore the meanings, to human beings in general, of this circumstance that death is inevitable—that human life is, like all other forms of life, innately finite.

CONCERNING SCHIZOPHRENIA

Psychoanalysis and intensive psychotherapy show us how infinitely varied and complex are the emotions which activate the human personality. These psychotherapeutic techniques show us that the interpersonal situations which individuals foster with other individuals, situations in which this gamut of human feeling-capacities is played upon with such richness, often are, from this psychological point of view, truly exotic. The analyst or therapist may develop the impression, as the facts of the patient's early-life exposure to lurid feeling-experiences unfold in the transference (experiences involving cannibalistic feelings, urges to dismember, incestuous feelings, and so on and on through infinite twistings and turnings and combinations) that these most strik-

*From the Chestnut Lodge Research Institute, Rockville, Md. This research was supported by a grant, to the institute, from the Ford Foundation. The author is grateful to Drs. Joseph H. Smith, Berl D. Mendel, Leslie Schaffer, and Donald L. Burnham for their helpful suggestions concerning a preliminary draft of this paper.

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†In another paper, "Positive feelings in the relationship between the schizophrenic and his mother,"[1] the writer discussed another, and to his mind similarly important, existential factor in schizophrenia; there he portrayed schizophrenia as a function of the struggle to express one's love constructively, certainly a general human struggle.

ingly *unusual* experiences in the *past* constitute, so to speak, the most potent wellsprings of anxiety, against which the illness has become created as a bulwark, or has formed as a system of scars over these ancient traumata. He will find such abundant evidence for this impression, an impression which has more than a little of theoretical validity and clinical usefulness, that he may ignore even more significant sources of anxiety which are resident in the patient's current situation, relatively colorless though this situation may appear in some instances, by contrast to highly extraordinary family situations from long ago.

For several years, the author has had the growing conviction that, out of all the welter of situational factors which play upon the human being's feeling-capacities, none is more potent than the simple fact that, for every individual, the whole complex business of living, this whole fascinating, agonizing, thrilling, boring, reassuring and frightening business, with all its moments of simple peace and complex turmoil, will some day, inescapably, end. To the writer, this seems a fact of life so significant as to be ranked, in psychological import, alongside those which have long been accorded fundamental places in psychoanalytic theory and practice—alongside, that is, such fundamental phenomena as weaning, Oedipal situations, the physiological and psychological concomitants of adolescence, and so on.

In the psychotherapy of schizophrenia, which has mainly concerned this writer for several years, it has seemed striking that, even in this overtly most exotic of psychopathological processes, the very mundane, universal factor of human mortality seemingly constitutes one of the major sources of anxiety against which the patient is defending himself—unconsciously, with his schizophrenic modes of intrapsychic experience and of interpersonal relatedness.

To be sure, schizophrenia can be considered a *result* of exotic, warping experiences in the past—predominantly in infancy and early childhood; but it can equally accurately, and with greater clinical usefulness, the writer thinks, be seen as consisting in the use of certain defense-mechanisms, learned very early, to cope with *present-day* sources of anxiety. And of these latter, none is more potent than the existential circumstance of life's finitude. In essence, then, the hypothesis here is that schizophrenia can be seen, from one among various other possible vantage-points,

as an intense effort to ward off or deny this aspect of the human situation. To the schizophrenic patient, this is—for reasons which will be detailed later—both more demanding of recognition, and more difficult to face, than it is to relatively well persons.

The author wishes to make quite clear that, in his experience, the fact of death's inevitability has a more than merely tangential relation to schizophrenia. That is, it is not a matter of the patient's becoming able, as he grows free here from his schizophrenia, to turn his attention yonder to that great life-circumstance of the inevitability of death—a circumstance which had previously lain inertly at the periphery of, or even quite totally beyond, his ken. On the contrary, the author's clinical work has indicated that the relationship is a much more central one than that: It is a matter, rather, of the patient's having become, and having long remained, schizophrenic (and reference here, of course, is to largely or wholly *unconscious* purposiveness) *in order to avoid facing,* among other aspects of internal and external reality, the fact that life is finite.

Only after several years of work with schizophrenic patients did the author realize that—precisely as the repressed seeks constantly to find access into awareness, so that repression is maintained only at the cost of unceasing vigilance and energy-expenditure—outer reality strives constantly, in a thousand and one incidents each day, to emerge into the patient's awareness. Thus, even the most deeply ill patient's delusions are under constant attack from the probing fingers of reality. To put this in unanimistic, less colorful, and more accurate terms, the schizophrenic patient's inner striving toward reality is an unceasing striving. In no instance, in the author's experience, is this striving so totally lacking that the reality-aspect under present discussion, the fact of death's inevitability, is utterly divorced from the subjective experiences of the patient's daily life, and devoid of relevance to the psychodynamics of his schizophrenia.

At Chestnut Lodge,* the twice-weekly, hour-long case presentations usually have to do with schizophrenic patients, for such patients constitute the majority of those being treated there. When the author went there, nearly 12 years ago, the therapists—including the author—presenting these cases often tended to paint a totally, or almost totally, black picture of the patient's child-

*Rockville, Md.

hood family relationships; the feeling-atmosphere of the presentation was one of blame of the parents more than anything else. As the years have gone on, the author has found that the presentations have come to convey less and less of such blame, and to convey more and more of the tragedy of the patients' lives—tragedy which is so much of a piece with the tragedy of life for all of us that the presentation is often a profoundly grief-laden experience for both the presenter and the listeners. One feels that the staff-presentation now gives a truer picture of a patient's life, but a picture which is much more deeply shaking than was the blame-colored picture previously often seen.

No doubt some of the change in the writer's view is due to a degree of personal maturation over these years. But others have commented on the same phenomenon; and the author believes that the staff members at Chestnut Lodge have indeed matured, individually and collectively, beyond the level of 12 years ago.

What it is intended to emphasize here is that a prominent *part* of this existential tragedy, which permeates the case history of the schizophrenic, has to do with the finitude of human life. There is tragedy in many other forms—as indeed there is in all human living—tragedy in the form of personal unfulfillment, family dissolution, separation from the locales of childhood, deeply-cherished relationships that have come to grief of one sort or another. But certainly the tragedy having to do with death's inevitability looms large here: The patient's parents are now elderly, and their deaths will obviously come before he can ever share with them a good relatedness whose years can equal those over which a predominantly pain-laden relatedness has extended. Or, in his childhood, the patient lost, through death, a parent or a nursemaid or a sibling who was obviously of the deepest value to him. Or he himself is now in middle life, and it is clear that when, even at best, his long treatment will be successfully concluded, only a comparatively few of his years will remain to him. And so on.

It was several years ago, in a setting of the author's psychotherapeutic relationship with a certain schizophrenic man, that the author sensed what depths of emotional challenge may be contained in so ostensibly simple a question as the stock one, contained in the traditional mental status examination,* as to whether a

*An interrogatory procedure which, the writer is glad to say, has never held sway —to the best of his knowledge—at Chestnut Lodge, since this became a psychotherapeutic hospital decades ago.

patient is reality-oriented in time, place, and person. For this particular man to be able to answer this question realistically, at a more than simply intellectual level, the writer realized, he would have to face the awesome tragedy involved in these circumstances of his present situation:

I am Charles Brennan, a man who is now, this being April 15, 1953, 51 years of age; who is living here in Chestnut Lodge, a psychiatric hospital in Rockville, Maryland; who has been living in a series of psychiatric hospitals constantly for eight years now; who has been seriously ill for over 25 years, with a mental illness which has robbed me of any realistic prospect, considering my present age, of ever being able to marry and have children, and which, quite possibly, will require my being hospitalized for the remainder of my life. I am a man who was once a member of a family which included two parents and seven children, but who has seen, over the years, a crushing series of tragedies strike this family: Years ago my mother died, in a state of long-standing mental illness; one of my brothers developed a mental illness as a young man, requiring extended hospitalization; another brother committed suicide; still another brother was killed in action in the second World War; and a third was murdered only recently, at the height of his legal career, by a mentally ill client. My remaining parent, my father, is now elderly, a man pathetically far removed from the strong man he used to be, and death cannot be far off for him.

To be sure, a patient does not have to say all this in answer to the traditional mental-status question concerning orientation; but, if his answer is to be more than merely intellectually meaningful, he must be able to feel all this and, of course, much more. What the author wishes to emphasize, concerning the hypothetical answer from this particular man, is its permeation by the recognition of life's finitude. To be sure, this man's situation is exceptional; an extreme example has been chosen in order to make the point. But the burden of tragedy in his answer is only *somewhat* greater than that which any schizophrenic must come to face if he is to become able, as it is so glibly put, to "face reality," and with these other patients, too, a considerable portion of the tragedy relates to death's inevitability.

Also within the past several years, the author has had the opportunity to work over very extended time spans with chronic, and initially deeply schizophrenic, patients. He has been impressed to see that, in one instance after another, whereas the patient's delusional ideas initially give one the impression of hav-

ing to do with luridly exotic matters, they prove to include, inconspicuously and seemingly tangentially—as a kind of colorless rider-clause—an ingredient which represents a denial of the finitude of life. To give but one example of this, the author's experience with a schizophrenic woman will be cited.

This woman was 28 when the writer began intensive psychotherapy with her; she had been overtly psychotic for at least four and one-half years, and had been hospitalized elsewhere for a year before her transfer to Chestnut Lodge. At the other hospital, she had had sporadic psychotherapy and several courses of insulin coma therapy and electric shock therapy. There was no improvement in the luxuriantly delusional paranoid schizophrenia from which she was suffering. After her transfer to Chestnut Lodge, one therapist worked with her for a year and a half before quitting in discouragement at the rigidity of her resistance to therapy and at the increasing, rather than diminishing, course of her delusional thinking.

Beginning with his first session with her and as the therapy went on, the writer found abundant evidence of a richly detailed, fascinatingly exotic and complex, extremely vigorously-defended delusional system, replete with all manner of horrendous concepts, ranging from brutal savagery to witchcraft, and to the intricate machinations of science-fiction. But toward the end of the first year of work, the author became increasingly impressed with the fact that although her perceptual world was in many respects far more frightening, miserable and horrible than that in which more normal persons live, her world contained fewer of such qualities in many other respects. One scrutinized it in vain for any of the *innate* tragedy which sane persons find in their world—tragedy having to do with such matters as illness, poverty, aging, and, above all, inescapable death. In the sixteenth month of treatment, she made quite explicit her view of this, when she stated, with vigorous protest:

> There's no reason for anybody in the world to be unhappy or miserable in the world today; they have antidotes for everything. They just keep pulling the wool over people's eyes. . . . People don't die [but in actuality are simply "changed," "moved about from place to place," made the unwitting subjects of motion pictures, and so on]. It's a government that has girded the earth with horror and hell!

It required nearly three and one-half years of continued psychotherapy before this woman had developed a predominantly reality-oriented view of the world and of herself. To the writer, the most memorable sign of this change was when she began to realize that life—including human life—is finite. One felt then that she was not merely taking fleeting glimpses of reality, as she had been doing increasingly during the previous three and one-half years, but was coming at last to face reality fully and to accept it. During the last few months before this realization, there had been an evident intensification of her delusional defenses against recognizing death's inevitability. She came to spend most of her time picking up dead leaves and the occasional dead birds and small animals which hours of searching revealed, and buying all sorts of articles from the stores in the nearby community, then by various alchemy-like processes, attempting to bring these to one or another form of life. It became very clear (and she herself substantiated this) that she felt herself to be God, selecting various dead leaves and other things to be brought to life. Many times the psychotherapeutic sessions were held out on the hospital grounds; the therapist sat on a bench, while she went on with her day-long scrutinizing of the lawn nearby.

But as these months wore on, toward the end of this period of denial of death, she came to express more and more openly a feeling of despair about this activity. Then there came an autumn day when, during the session, patient and therapist sat on benches not far apart and gazed together at the leaf-strewn lawn. She let it be known, mainly in nonverbal ways, that she was filled with mellowness, tenderness, and grief. She said, with tears in her eyes, in a tone as of resignation to a fact that simply has to be accepted, "*I* can't turn those leaves into sheep, for instance." The therapist replied, "I gather that you're realizing, perhaps, that it's this way with human life, too—that, as with the leaves, human life ends in death." She nodded, "Yes."

This marked an openly-acknowledged acceptance of two great aspects of reality simultaneously: that she was not God—that she could not be held responsible for man's mortality—and that we human beings are mortal. This showed that the very foundation of her paranoid schizophrenic illness was now crumbling, an illness which had involved her years-long conviction, for example, that both her deceased parents were still living.

To cite another instance, a 37-year-old woman was suffering from a hebephrenic illness when the author became her therapist. She had been hospitalized most of the time for the preceding eight years, and a lobotomy had been recommended before her transfer to the Lodge for a last-ditch trial of intensive psychotherapy. It required slightly more than six years for her to become able to accept the inevitability of death. During those six years, a kaleidoscopically-changing variety of schizophrenic manifestations revealed themselves in the therapy. These were seen, not so much in verbalizations of her delusional thinking, which was relatively undetailed in keeping with the deeply-fragmented state of her ego, as they were in her nonverbal behavior (bizarre modes of dress, weird laughter, and so on). To the extent that she was able to verbalize her thinking, it was evident that she experienced the world as being dominated by omnipotent father-figures and omnipotent nonhuman forces. The therapist has seldom felt so moved as he did when, after her very deep confusion had steadily lessened over the years, she verbalized a poignant realization of the finitude of life. She expressed this, at first, with a kind of child-like, puzzled, protesting refusal-to-believe—not very different, probably, from some of the feelings which any human being finds in his heart as he comes face to face with this insurmountable fact of his existence.

She said, "People don't live more than a hundred years," in a tone as if to say that people say this; it doesn't make any sense, but that is what people all say. "... I'm going to live more than a hundred years [touching determination in her tone] ... Why do people die? They say the heart expires. ... Why should the heart expire? ..." In a session not long after this, she asked, "Why does a person die? Their heart wears out, is that it?" and went on—after the therapist had agreed that this was the most common cause of death—to express a child-like puzzlement and protest as to why "they" don't do something about this problem, why they don't "duplicate" the heart. "A mirror duplicates things," she pointed out. "I *can't* understand it," she said protestingly and frustratedly.

In subsequent sessions, she made clear that the anxiety and sorrow associated with this so-objectionable fact had to do not only with concern about her own existence, but also with concern for

deeply-beloved persons in her life, some of whom were now dead, and some of whom were living but elderly.

The feeling-tone of the schizophrenic's eventual realization of the innate finitude of life is not different, in the writer's experience, from that of the neurotic. The author had been aware for several years that this poignant realization is a feature of the relatively late phases of neurotic patients' psychoanalyses; what he had not realized, until the last few years, is its significance in schizophrenia also. It has now become evident to him that a beautiful poem by Marcia Lee Anderson expresses a truth which is valid for us all, whether we be "normal," neurotic, or schizophrenic:

DIAGNOSIS

We multiply diseases for delight,
Invent a horrid want, a shameful doubt,
Luxuriate in license, feed on night,
Make inward bedlam—and will not come out.
Why should we? Stripped of subtle complications,
Who could regard the sun except with fear?
This is our shelter against contemplation,
Our only refuge from the plain and clear.
Who would crawl out from under the obscure
To stand defenseless in the sunny air?
No terror of obliquity so sure
As the most shining terror of despair
To know how simple is our deepest need,
How sharp, and how impossible to feed.*

In working with schizophrenic patients, one soon comes to realize that many, if not all, of them are unable to experience themselves, consistently, as being *alive*. The author has long thought that this has to do mainly with their widespread repression of the gamut of their feelings—feelings of all sorts. But he has come to wonder whether this repression *in toto* may serve an additional defensive function: One need not fear death so long as one feels dead anyway; one has, subjectively, nothing to lose through death.

And it certainly seems to the writer that a second great aspect of schizophrenic symptomatology, the fantasy of personal omnipotence, ties in closely with the subject of this paper. It is often mentioned that the schizophrenic patient views himself, and other

*The author is indebted to Dr. Robert A. Cohen for having acquainted him with this poem.

persons, as being omnipotent; but we need to remind ourselves that the companion of omnipotence is immortality. These two subjective qualities are, in fact, two sides of the same coin; whenever the gods are thought of they are assumed to be *immortal* gods.

Having touched upon the evidences that schizophrenia is a defense against recognizing the inevitability of death (among other anxiety-laden aspects of inner and outer reality, against which it is also a defense), the author wishes now to take up the central question of *why* the schizophrenic individual, unlike the normal-neurotic individual, has been unable to recognize and accept this aspect of reality.

First, it can be said that the anxiety concerning life's finitude is too great to face unless one has the strengthening knowledge that one is a whole person, and is, with this wholeness, able to participate wholly in living—able to experience one's self as a part of the collective wholeness of mankind, all of whom are faced with this common fate. A person cannot bear to face the prospect of inevitable death until he has had the experience of fully living, and the schizophrenic has not yet fully lived. (In saying this, I have in mind not only clinical experiences with patients, but also my personal experience. Not until I had had many months of personal analysis did I come to experience a sense of peace with respect to the fact of my eventual death; I remember well that at the end of a certain day, I felt that I had known for the first time, this day, what it was to really live; and simultaneously I found that I was no longer burdened by the prospect of death. I was astonished that it had required but one day of real living to work this curative result. It has been said that a man cannot bear to die without having really lived; but I found that one does not have to experience 30 years of real—i.e., relatively wholly participating—living to make up for the previous 30 years of existence as a less-than-whole person. One day, I found, was sufficient to enable me to face the threat of death with equanimity. This equanimity, though disturbed for varying periods in the intervening years since that day, has never been wholly lost to me, and forms what I feel to be the strongest and most basic of my feelings about death. The rest of this discussion will deal primarily with my clinical experience with schizophrenic patients

who have gone on to, or—as in most of these instances—a long way toward, recovery.)

Second—and these are not separate features of the schizophrenic's past, but aspects of a single complex situation—the losses which the schizophrenic has already experienced have come too early in his development, and in too great magnitude, for him to have been able to integrate them. Perhaps, if it were possible for him to experience his sense of loss fully, at a phase of his life when durable object relationships had not yet been established, he would experience a feeling, not of "loss" in the mature sense, but rather of disintegration of the total self.* Thus, such a person would react to these losses, because of the immaturity of his ego, with various pathological defense mechanisms—with, most of all, reinforcement of his subjective infantile omnipotence, which involves his conviction that he has suffered no loss, and that it is unthinkable that he could ever suffer loss, for he is the whole world. Thus, not having been able to integrate losses in the past, he is unable now to integrate the prospect of the greatest of all losses, that is the loss which stems from the mortal nature of himself and of everyone he knows. He meets this supreme threat of loss with his habitual defense mechanism of subjective omnipotence—a defense mechanism which is, as already mentioned, so prominent a feature in any schizophrenic illness.

The early losses referred to are seen in any of the hundreds of schizophrenic patients' case presentations known to the author in many years at Chestnut Lodge. These include, very often, the death, or otherwise physical departure from the scene, of deeply significant persons in the infant's or young child's life; or the psychological withdrawal of an erstwhile mothering figure. In the latter connection it is of interest that Lewis B. Hill,[2] after much longer experience than the writer's with the psychotherapy of schizophrenic patients, states:

> There is . . . evidence that many of the mothers of schizophrenics actually accepted their babies warmly and took excellent animal care of them while these babies were small and were not regarded as individuals having any will or wilfulness contrary to that of the mother. . . .[2, p. 111]

Third, in direct line with what has just been said about early losses, the symbiotic relatedness between infant and mother, while normally found in infancy, is, in the life of the future schizophrenic,

*A concept suggested to the author, in another connection, by Dr. Robert A. Cohen in 1955.

prolonged into chronological adulthood. The "mother" in this symbiosis may be the mother herself, a nursemaid, the father in occasional instances, or later figures in the patient's life toward whom this kind of relatedness becomes transferred. The presence of this symbiotic relatedness in the schizophrenic's life-history has been described by a number of writers, including Reichard and Tillman,[3] Lidz and Lidz,[4] Mahler,[5] Hill,[2] and the writer,[1, 6] and only certain aspects of it which are of greatest relevance here will be discussed.

In such a relatedness, each person finds himself oscillating helplessly between a position of intense "closeness" with the other person, and an utterly contrasting position of total psychological divorcement from that person, the latter position being experienced as a sense of having completely *lost* the deeply cherished relatedness of a moment before. It may well be that, for the adult schizophrenic patient, the prospect of death is intolerably reminiscent of such experiences of loss—and, of course, of similar experiences in the present with parent-figures—of bleak, death-like interruptions in his sense of contact with this other person who is felt to be necessary to his very survival.

There is another respect in which such a relatedness involves tremendous loss, if one can apply the term "loss" to something which one has not yet had: the patient's loss of the experiencing of himself as a relatively wholly-integrated person, at both intrapsychic and interpersonal levels. The symbiotic relatedness requires, for its maintenance, that neither party experience himself, or herself, as a whole person; instead, each needs the other's personality to complement his or her own personality, in order to achieve anything like a sense of "wholeness." Moreover, this symbiosis precludes a sense of wholeness, on the part of either person or of both together, with the larger world of collective mankind; typically, this is a two-against-the-world kind of relationship. This larger world, comprised of all persons outside the symbiotic relationship, must be kept at a distance psychologically, rather than related to, closely and realistically, if for no reason other than the child's and the mother's need to project upon it various intensely negative affects which are engendered in both of them by the very nature of their extremely constricting symbiosis with one another.

In addition to the loss-of-subjective-wholeness aspect of this symbiosis, there is another aspect of it which militates also against the child's developing in such a way as to be able to meet, in chronological maturity, this great fact of the inevitability of death. That is, this symbiosis involves, on the part of both persons, a subjective—and repressed—infantile-omnipotence, in keeping with the basically very infantile nature of this relationship, a relationship which is normally found only between the infant and the mothering one, as has been pointed out by Mahler.[5]

The child who eventually develops schizophrenia needs, in his chronological maturing, to maintain this subjective omnipotence as a defense against various threats, internal and external, in addition to the threat involved in the recognition of human mortality. He needs it to cope with, among other lesser threats which there will be no attempt to list comprehensively, his profound, repressed sense of helplessness in the face of his mother's, and his own, very intense ambivalence. As described elsewhere by this writer, he and his mother do not simply bear murderous hatred and intense rejectingness toward one another, but equally genuine and powerful love.[1] He has a sense of profound personal helplessness in the face of his feeling his deepest hate toward the person whom he most deeply loves, and helplessness in the face of his fear of this person who is at once the most important person in his life and who loves him intensely, and is at the same time the person who above all others hates him too. It is this sense of personal helplessness which, more than anything else, requires his maintenance of the fantasy, normal only in infancy, of personal omnipotence.

Nothing else would so completely demolish this subjective omnipotence, this so desperately needed defense, as would his recognition of the inevitability of death; a human being is never more aware of his own powerlessness than he is when experiencing the recognition of this.

But among the many psychological prices which he pays for thus clinging to this cherished defense, this subjective omnipotence, there is a great complicating of his perceptual picture of the reality-aspect which more normal persons experience as life's innate finitude. The resultant complexity makes it inordinately difficult, then, for him to sort out perceptually, and become aware

of, this fact of human life, for it has become thoroughly entangled with his defensively-distorted views of himself and of the world.

Every schizophrenic person, or young person who is on the road to schizophrenia, has a great deal of repressed hatred within him, and has a view of himself—whether in consciousness or at a repressed level—as a creature bearing within himself an omnipotent malevolence. Thus what is normally experienced as realistic death which will inevitably come to embrace every human being, he tends to experience in terms of a projection of his own supposedly all-powerful destructiveness; he tends, then, to feel personally and totally *responsible for* death itself, as he is indeed responsible—more, certainly, than anyone else—for his own feelings, including his hatred, whether it be conscious or unconscious.

So, before he can face the fact of man's innate susceptibility to death, he must come to know clearly that he does not carry the seeds of mankind's destruction in his own breast. This necessitates prolonged working-through of his erstwhile-repressed hostility; and, only when he can mature to a point where his love is greater than his hatred, and where he can feel convinced that this is so, can he find the assurance that mankind's mortal nature is not to be laid at the door of his own personal responsibility. Prior to that development, he tends to equate the existential fact of death's final victory with the fact that his own hatred repeatedly triumphs over the forces of love in himself.

The psychological state of his partner in the symbiotic relationship—most often his mother—is such as to add to the complexity of his problem in coming to face this aspect of reality. She, too, clings to a fantasy of subjective omnipotence and she herself also possesses deeply ambivalent feelings. One must not forget that the ego-boundaries demarcating these two persons are very incomplete. Thus, for him, existential death tends to wear the countenance of his mother's repressed and projected murderousness, mingled with his own.

His incomplete ego-integration, and his painful experience of apartness, not only from other persons (as mentioned in the description of the symbiotic mode of relatedness), but from his own self, tend to make him react to existentially-normal death, with its connotations of physical disintegration and removal from the world of living beings, as tantamount to both the intrapersonal and interpersonal experiences of psychological nonintegration

which have caused him his most intense suffering. Thus he tends to react to existential death, as this moves toward his awareness (although as a not-yet-realistically defined perception) with feelings of not only personal guilt, but of irrational anxiety. One of the writer's schizophrenic patients, as she started to come to grips with this aspect of reality, became obsessed for months with efforts to arrange to have her body, after death, kept indefinitely in a deeply frozen state, so that it would not "fall apart"—the same phrase she had used, for years, in reference to her experiences of psychological disintegration.

One might say that every human being faces this dilemma: He cannot face death unless he is a whole person, yet he can become a truly whole person only by facing death. But so long as one is still schizophrenic, one is much less well able to meet this dilemma successfully; one is much *too* unwhole to do so. Only a relatively whole man can experience a sense of participation in the wholeness of mankind, a sense that is so deeply reassuring in the face of the knowledge of death, as William Cullen Bryant's poem, *Thanatopsis*,[7] beautifully conveys:

> Yet not to thine eternal resting-place
> Shalt thou retire alone, nor couldst thou wish
> Couch more magnificent. Thou shalt lie down
> With patriarchs of the infant world—with kings,
> The powerful of the earth—the wise, the good,
> Fair forms, and hoary seers of ages past,
> All in one mighty sepulchre. . . .
> . . . . . .
> . . . All that tread
> The globe are but a handful to the tribes
> That slumber in its bosom. — . . .
> . . . . . .
> So shalt thou rest—and what if thou withdraw
> In silence from the living, and no friend
> Take note of thy departure? All that breathe
> Will share thy destiny. The gay will laugh
> When thou art gone, the solemn brood of care
> Plod on, and each one as before will chase
> His favorite phantom; yet all these shall leave
> Their mirth and their employments, and shall come
> And make their bed with thee. As the long train

Of ages glides away, the sons of men,—
The youth in life's fresh spring, and he who goes
In the full strength of years, matron and maid,
The speechless babe, and the gray-headed man—
Shall one by one be gathered to thy side,
By those, who in their turn shall follow them.

So live, that when thy summons comes to join
The innumerable caravan, which moves
To that mysterious realm, where each shall take
His chamber in the silent halls of death,
Thou go not, like the quarry-slave at night,
Scourged to his dungeon, but, sustained and soothed
By an unfaltering trust, approach thy grave
Like one who wraps the drapery of his couch
About him, and lies down to pleasant dreams.

From what has been described of the psychodynamics of schizophrenia two implications emerge for a therapeutic approach which will help the patient to become able to face the inevitability of death.

The first implication is an obvious one: The therapist's awareness of these psychodynamics enables him to help the patient to unravel this reality aspect from the complexities of his delusional thinking. The therapist's awareness will also help him to understand why the patient's recognition of the inevitability of death can only follow a prolonged working through of hatred, guilt, and anxiety.

The second implication is simpler, but if anything more important, than the first: It is essential that the therapist himself be well aware, at a more than simply intellectual level, of life's finitude, and that his whole therapeutic approach be conducted in the light of his recognition of it. The chronically schizophrenic individual often requires deep and genuine patience from the therapist; the latter is often required—or one might say allowed, for there is a pleasurable side to this, too—to function as though time did not exist, in order to nourish the patient's slow growth out of an ego-shattered state. Many a therapist shies away from this phase of the treatment, for it tends to be deeply frustrating-and-gratifying to infantile dependency needs, whose presence within himself he cannot acknowledge.[8] But the time comes, in every instance in which treatment is successful, when the therapist must

gradually oppose, more and more firmly, a powerful tendency in the patient-therapist relationship toward becoming bogged down in the timeless, infantile-omnipotent world of the schizophrenic —a world which the therapist has had to share, to a degree, in empathizing with the patient, and a world which holds powerful allure for the vestigial infant in each of us. Thus, although the therapist earlier had to be predominantly patient and undemanding, he can now be (and in fact it is essential that he now be) unashamedly impatient with the schizophrenic's continuing to function as though an eternity of time remained in which to carry through the mutual therapeutic task.

Concerning Human Beings in General

In the writer's experience, any successful, long-range psychoanalysis or psychotherapy comes to involve the patient and the doctor in facing life's most basic issues together, even though the doctor may be participating little in an overt, verbal fashion. Each emerges, when the treatment is over, with a deepened and enriched understanding of life's meaning. Certainly, in working with schizophrenic patients, the therapist must, in the course of helping the patient to face the fact of the inevitability of death—a facet of reality which, as has been indicated, is the focus of so much anxiety for the patient—search deeply into the meanings which this existential fact holds for the therapist *himself* also.

Thus the writer's work with schizophrenic patients has comprised one of the wellsprings of his interest in the meaning which this subject—the finitude of life, the inevitability of death—holds for human beings in general. A second major source of his interest was comprised in a series of bereavements, occurring between six years and a year and a half before this was written. Since the most recent of these, sufficient time, thought, and working through of feelings have been expended for the writer to feel himself capable of bringing to this presentation both a degree of personal interest and one of considered thought.

This is a subject which present-day Western culture tends mainly to discourage one from investigating, from thinking about often or deeply. Our culture predominantly fosters in us, psychiatrists and laymen alike, a readiness to ignore it altogether. Our nonrecognition of death's inevitability is encouraged not only by the prevalence of such escape-entertainment media as television,

the radio, and motion pictures, but in less obvious ways also. To the extent that we are kept preoccupied by the quite realistic fear that international tensions may lead to a global holocaust at any time, and thus wipe out our lives, we are shielded, paradoxically, from the ineradicable fact that, no matter whether the dim chance of international peace brightens, human life is in any case finite. And to the not inconsiderable degree that suicide is prevalent (and the tremendous toll which is exacted, annually, by highway accidents suggests that unconscious suicide may be vastly more prevalent than conscious, unmistakably identifiable suicide), then, again paradoxically, a segment of the population may be thought of as having rejected the full recognition of life's innate finitude, through its members having subjectively willed—consciously or unconsciously—their own deaths. And modern medicine, with its highly publicized campaigns to lower the statistics which show us that so-and-so-many persons out of 10 die of cancer, or heart disease, and so on, foster—however valuable are these campaigns in other respects—our overlooking the fact that, no matter how highly developed medical science becomes, out of every 10 persons there will still die, from one cause or another, 10.

Further, to the extent that a culture is permeated—as is our own—with thinking which is couched in the frame of reference of *blame,* we tend to shield ourselves from the inescapable conditions of our existence, one of such conditions being the inevitability of death. In the writer's description, earlier in this paper, of the changed atmosphere of the staff presentations at Chestnut Lodge, the impression was noted that, in this miniature "culture," the atmosphere of blame which had prevailed, years ago, had served to shield the staff from a relatively full awareness of the innate tragedy of the patients' lives. And similarly in one's daily life in the larger culture, when someone we know dies, we tend to become involved in feelings of blame, whether of other persons or of ourselves, rather than to regard the death as something which is a natural part of our existence. It is not meant here, of course, that mankind should passively accept the ravages of disease, or of human suffering in any form; but the fact of our innately mortal nature must be accepted if one is to know what it is to live in peace.

The author wishes finally to suggest, before leaving this aspect of the subject for the time being, that our culture's whole emphasis

upon the use of *verbal communication* may serve to shield us from the reality of death. Benjamin Lee Whorf,[9] in particular, has expounded what has come to be known as the Sapir-Whorf hypothesis, which states in essence that our thinking, and our perception of the world about us, is limited by the nature of the language which our culture employs—instead of language possessing, as had previously been widely assumed, a much less significant, purely instrumental, function in our living. Edward Sapir, under whom Whorf had studied, had phrased the hypothesis thus:

> Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language which has become the medium of expression for their society. It is quite an illusion to imagine that one adjusts to reality essentially without the use of language and that language is merely an incidental means of solving specific problems of communication or reflection. The fact of the matter is that the "real world" is to a large extent unconsciously built up on the language habits of the group. . . . We see and hear and otherwise experience very largely as we do because the language habits of our community predispose certain choices of interpretation.[9, p. 134]

Langer[10] notes that Bertrand Russell, in a philosophical work written in 1900, had pointed out the essential principle embodied in the Sapir-Whorf hypothesis.[10, p. 55]

If one grants, then, the premise that our particular language tremendously conditions—not only consciously but unconsciously—our thought-processes and our view of "reality," then it follows that our culture's great emphasis upon *verbal* communication results, by way of the segmentation and abstractification which are involved in discursive language, in our having not only consciously but unconsciously a segmented and abstractified experience of our existence. Such a mode of experiencing our life tends to shield us from the continually-flowing rhythm of our actual existence, the essential continuity of birth-growth-decay-death. That is, the writer thinks, these would not be experienced, if we knew them face-to-face, in the segmented form in which one must present them through the limited medium of verbal language. A verbal-language view of life tends to shield ns, that is, from experiencing existence as involving a concrete and continual relatedness to death.

Such cultural factors as those here mentioned may account, in part, for the relative paucity of psychoanalytic and psychiatric

literature on this subject. But it is, nonetheless, somewhat puzzling to find that scant attention has been paid, in the professional literature, to a subject whose importance in human living is attested by the position of great prominence which it has long occupied in the world's various religions, in myths, in general literature, and in philosophy.

In our own culture, religion is one of the very few institutions which repeatedly puts before us this basic fact of our existence, the fact of death—even though it presents a palliative at the same time, in the form of a concept of life after death, to relieve the harshness of this fact of death. Apparently religions from time immemorial have attempted, in some manner or other, to grapple with the fact of death. Suzanne K. Langer, in *Philosophy in a New Key—A Study in the Symbolism of Reason, Rite, and Art,*[10] says:

> ... Life and life-giving, death and the dead, are the great themes of primitive religion. ...[10, p. 122]

And of myths, she says:

> Myth ..., at least at its best, is a recognition of natural conflicts, of human desire frustrated by non-human powers, hostile oppression, or contrary desires; it is a story of the birth, passion, and defeat by death which is man's common fate. ...[10, p. 143]
>
> ... *the culture-hero* [in the myth] *is Man, overcoming the superior forces that threaten him.* A tribe, not a single inventor, is unconsciously identified with him. The setting of his drama is cosmic; storm and night are his foes, deluge and death his ordeals. These are the realities that inspire his dream of deliverance. His task is the control of nature—of earth and sky, vegetation, rivers, season—and the conquest of death.[10, p. 150]

Likewise in most great literature, one is never far removed from facing this theme of death's inevitability. Perhaps one symptom of the relative mediocrity of much of our current literature is the fact that it seldom attempts to deal with this so-basic facet of human existence. There is no lack, in today's literature, of accounts of death by human violence; but only seldom is a modern novel couched in terms of human existence as being quite *innately* terminated by death. It seems to the writer that the best of our novels are those which include cognizance of this theme. For example, in James Jones' *From Here to Eternity,*[11] and James Gould Cozzens' *By Love Possessed,*[12] this theme forms the ever-present background of both novelists' narratives.

Philosophy, too, of course, from its beginnings has always striven to come to terms with, among other facets of human existence, the fact of death. A brief sampling of some of the tenets of a relatively recently-developed school of philosophy which is of much interest to the behavioral sciences, Existentialist philosophy or ontology—will show that the finitude of man's life is one of the most central concerns of this system.

Concerning Heidegger's existentialism, Eissler[13] writes:

> The cornerstone of Heidegger's ontological analysis of existence (1927) is the presence of death in each moment of life prior to the actual occurrence of death. . . . existential analysis reveals that existence is *existence (or being) toward death (Sein zum Tode)*. . . . in the system of Heidegger's onotology, dying does not mean that existence has reached an end; rather, death is a mode of being upon which existence enters as soon as it has begun.[13, pp. 4-6]

O. F. Bollnow is quoted, in Eugen Kahn's recent review of existential analysis,[14] as holding:

> To exist means to be faced with death.

Ludwig Binswanger is paraphrased by Edith Weigert[15] as asserting, similarly:

> Being-in-the-world is existence towards death.

And lastly Paul Tillich, a theologian whose existentialist volume, *The Courage to Be*,[16] is one of the relatively few such works available in English, presents the anxiety concerning death as one of the foundation-stones of his views of man's psychology:

> . . . The first assertion about the nature of anxiety is this: anxiety is the state in which a being is aware of its possible nonbeing. The same statement, in a shorter form, would read: anxiety is the existential awareness of nonbeing. "Existential" in this sentence means that it is not the abstract knowledge of nonbeing which produces anxiety but the awareness that nonbeing is a part of one's own being. It is not the realization of universal transitoriness, not even the experience of the death of others, but the impression of these events on the always latent awareness of our own having to die that produces anxiety. Anxiety is finitude, experienced as one's own finitude. This is the natural anxiety of man as man, and in some way of all living beings. It is the anxiety of nonbeing, the awareness of one's finitude as finitude.[16, pp. 35-36]

Valuable as is the emphasis placed upon this theme, namely the psychological significance of human mortality, in existentialist writings such as the few mentioned here, one seldom gets from them a sense of the basically *uniquely individual* impact upon one's self of this fact, that one is, like all one's fellow human beings,

mortal; Tillich is unusual, among such writers, in stressing, as noted here, the anxiety having to do with one's *own* individual death. Binswanger is apparently more typical of such writers, in couching his views in terms of mankind as a whole, a frame of reference which necessarily entails much dilution of individual poignancy:

> ... If we talk of human existence, ... we *never* mean human existence, as mine, thine, or his, but human existence in general, or the human existence of mankind ...[14, p. 217]

Weigert[15] has called attention to this breadth of existentialism's focus:

> ... Existentialism is not interested in individual psychopathology; it describes certain basic irreducible dialectic trends like One and Self, Care and Love, which determine existence in our culture. The psychotherapist looks at trees, the existentialist at the forest as a whole ...

Coming now to the contributions of psychoanalytic literature concerning this subject, let us look first at Freud's writings. In "Thoughts For the Times on War and Death,"[17] written in 1915 in a state of profound disillusionment about the First World War, he distinguished three different basic attitudes in us, regarding death. Our own death is, he says, unimaginable to us; the deaths of our enemies are desired by us; and the deaths of our loved ones arouse ambivalent reactions in us:

> ... Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence the psycho-analytic school could venture on the assertion that at bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality.
>
> On the other hand, for strangers and for enemies, we do acknowledge death, and consign them to it quite as readily and unthinkingly as did primitive man. ...

Then, after describing our unconscious ambivalence toward the deaths of our loved ones, Freud says,

> To sum up: Our unconscious is just as inaccessible to the idea of our own death, as murderously minded towards the stranger, as divided or ambivalent towards the loved, as was man in earliest antiquity. ...

In 1920, in *Beyond the Pleasure Principle*,[18] Freud put forward his concept of a death instinct in man, a concept which came to form a major component of his definitive over-all theory of human psychology. But, to the present writer's mind at least, it tended for many years (to the degree that this now largely-abandoned

concept was embraced by his followers) to obscure the deepest significances of the inevitability of death. Specifically, the author believes that this concept obscures the fullness of the impact which this fact makes upon us: The potential poignancy, terror, rage and sorrow which it holds are all diluted in a conceptual view which maintains that, to a marked degree, each of us unconsciously *longs for* this inevitable event. The writer believes that a longing for death is, indeed, one among our many attitudes toward it; but he believes that Freud's concept of a death instinct of almost unparalleled power, followed by subsequent writings in psychoanalysis which have tended either to prove or disprove this theory, have served to distract us from looking into the depths of poignancy—a poignancy far more complex than some mere two-sidedly conflictual matter—which is aroused in us by our awareness of death's inevitability.

Eissler, in *The Psychiatrist and the Dying Patient,*[13] published in 1955, subscribes to Freud's theory of a death instinct, and even suggests that death may always be psychological in nature—that death in whatever form, whether or not it is *overtly* a suicide, may involve the ego's having decided, as it were (and here Eissler is paraphrased), to die. Although he puts this forward as a tentative hypothesis, he dwells upon it at such length as to indicate that he is much impressed with this possibility; the following passage merely introduces his relatively lengthy case for the hypothesis:

> ... There is still the faint possibility that man could die only when the inherent forces of life have lived out their potential or when an inner complication forces the ego to turn the balance in favor of the ever-ready forces of internal destruction. ...[13, p. 106]

Such a viewpoint colors much of Eissler's book, including the bulk of it which has to do with the specific title-subject of psychotherapy with the dying patient. A major technique which, he feels, helps the patient to endure the "final pathway" is the psychiatrist's helping the patient to feel that the psychiatrist is identified with him in facing death. But one gets the impression that this is, indeed, recommended primarily as a *technique,* something which is of use to the patient here; that the psychiatrist does not identify with the patient in a really deep sense; and that, above all, Eissler does not appear to look upon this situation as one in which the

psychiatrist's view of his *own* inevitable death is plumbed in its deeper meanings:

> . . . A part of the therapist's ego must remain free of identification. As has been remarked earlier, even the belief in immortality must be activated. If the therapist's own fear of death is considerable, he will either recoil from even a partial identification or become anxious, if not depressed. . . . the main function of the identification is . . . to make it possible for the patient to establish a therapeutic relationship which is at all usable. . . .[13, p. 250]

If the author were a dying patient, and in psychotherapy, the greatest service a therapist could render him would be that of, beyond helping him to face the fact of his own coming death, giving him to know that the relationship was also being of use to the therapist in his own adjustment to the death which will inevitably come to him as it is coming, sooner now, to the dying patient.

Eissler expresses the troubled rumination:

> . . . there was no doubt that in Case Two it would have helped if I could have told the patient that I, too, was suffering from a disease bringing me slowly closer to death. In this moment a community of spirit would have been established which would have permitted an identification on her side.[13, p. 246]

The author feels that we all *do* suffer from something which brings us slowly closer to death—namely, aging; and to the degree that a psychiatrist need not shield himself from this fact in the deepest levels of his being, the closer and more genuine can be the communion felt with a dying patient. The writer will not go further into this special aspect of the subject, with which Eissler mainly deals; but, in leaving it, he wishes to emphasize that this is not an aspect which is far off to one side from the everyday practice of psychotherapy and psychoanalysis. Eissler's book can help one to become clearer about philosophical matters which not only are involved in the psychiatrist's relatively rare work with patients who are close to death, but which underlie all our work with patients, for surely one criterion of maturity, which we endeavor to help patients in general to achieve, is their ability to face, and live with, the knowledge of the mortal nature of human life. Eissler devotes part of his attention to the more general aspects of this subject—the psychological significances, to man, of the fact that he must eventually die—and presents a review of the relatively sparse psychoanalytic literature on this subject, a review which need not, therefore, be duplicated in this paper.

In addition to Freud's controversial death-instinct theory, a second characteristic of the developmental history of psychoanal-

ysis has tended to minimize the significance of death: the preoccupation of psychoanalysis with the first few years of the patient's history. Of interest in this connection is a comment made in 1946 by Hartmann, Kris, and Loewenstein.[19] After describing the development of the super-ego organization in the child, they emphasize:

> The development of personality is not concluded at this point, and we feel that the potentialities of its transformation throughout latency and adolescence have for some time been underrated in psychoanalytic writings. ...

However essential it is that the very early period of life be focused upon strongly as of preponderant importance in the development of the personality, it should be seen that this is a period in which the individual is normally but little occupied with the reality of his own, and other persons', innate susceptibility to death. This aspect of reality tends to remain principally over the horizon until one's life course is to a very significant degree already run—that is, half-run, or so. Even adolescence, which has marked the outer limit of most of the ground covered by psychoanalytic theory, knows little of the feelings which come in later years about this, when death is a clearly visible reality and we find, in fact, that we have already walked half way, or much more than half way, to it.* In relatively recent years writers such as Therese Benedek[21-23] have explored some of the psychological phases of life after adolescence, after "maturity" has been reached; this present paper is intended as a contribution to such studies. Incidentally, it may be no coincidence that members of the very age group, the elderly, to whom the reality of death looms largest, have been considered relatively unsuitable for psychoanalysis or intensive psychotherapy. Perhaps as analysts and therapists come more to grips with the significance of death, we shall have the

*But it may be that adolescence possesses a feature which psychoanalysis has largely overlooked: a *beginning* attempt to face death's inevitability. The presence of such an ingredient in normal adolescence is suggested by the fact that so many adult schizophrenic patients, who—as indicated in the first part of this paper—have such intense difficulty with this matter of life's finitude, became schizophrenic in adolescence. And the following comment by Erikson[20] is additionally suggestive:

"In extreme instances of delayed and prolonged adolescence an extreme form of a disturbance in the *experience of time* appears which, in its milder form, belongs to the psychopathology of everyday adolescence. It consists of a sense of great urgency and yet also of a loss of consideration for time as a dimension of living. The young person may feel simultaneously very young, and in fact baby-like, and old beyond rejuvenation. ..."

personal courage and understanding to work more deeply with elderly persons, and shall find that they are better "candidates" for therapy, or even analysis, than we had long assumed them to be. We shall be encouraged to enter into such work, for example, in proportion as we become convinced that even a single moment of deeply-felt intrapersonal and interpersonal relatedness is subjectively timeless, eternal, and "makes up for" several decades of living as a less-than-whole person.

In psychoanalytic theory, we have too often tended to limit ourselves to thinking that a patient's preoccupation with the subject of death connotes only some pathological reaction, whether a phobia about death, or guilt-laden death wishes, or what-not. Death as a great aspect of reality, an aspect whose reality needs to be recognized by the patient—and an aspect which no psychoanalysis of whatever depth and thoroughness can ever efface, but only more clearly delineate—is seldom mentioned in our professional literature. We tend to forget, for example, when a phobia about death is being discussed, that even after the *symbolic* meanings to the patient of "death" have been brought to light, and there has been a resolution of the neurotic anxiety concerning heretofore-unconscious affects (concerning sex, aggression, passivity, or whatever) which have presented themselves in the guise of anticipated death, there will still remain the *reality* of death itself, and the anxiety realistically associated with it.

Erich Fromm,[24] while in the opinion of the writer giving certain of man's interpersonal conflicts—such as those arising from the Oedipus situation—less than their due, accords a full and eloquent acknowledgment to the significance of human mortality; Fromm makes it, in fact, one of the cornerstones of his theoretical system (which he calls humanistic psychoanalysis), and his views provide a valuable counterbalance, therefore, to the emphasis which classical psychoanalysis has placed upon instinctual factors:

> . . . the main thesis of humanistic psychoanalysis: that the basic passions of man are not rooted in his instinctive needs, but in the specific conditions of human existence, in the need to find a new relatedness to man and nature after having lost the primary relatedness of the pre-human stage. . . .[24, p. viii.]

Self-awareness, reason and imagination disrupt the "harmony" which characterizes animal existence. Their emergence has made man into an anomaly, into the freak of the universe. He is part of nature, subject to her physical laws and unable to change them, yet he transcends the

rest of nature. He is set apart while being a part; he is homeless, yet chained to the home he shares with all creatures. Cast into this world at an accidental place and time, he is forced out of it, again accidentally. Being aware of himself, he realizes his powerlessness and the limitations of his existence. He visualizes his own end: death. Never is he free from the dichotomy of his existence: he cannot rid himself of his mind, even if he should want to; he cannot rid himself of his body as long as he is alive—and his body makes him want to be alive.[24, pp. 23-24]

Fromm's views, written in 1955, are similar in content, and in eloquence, to these of Langer,[10] written in 1942.

For good or evil, man has this power of envisagement, which puts on him a burden that purely alert, realistic creatures do not bear—the burden of understanding. He lives not only in a place, but in Space; not only at a time, but in History. So he must conceive a world and a law of the world, a pattern of life, and a way of meeting death. All these things he knows, and he has to make some adaptation to their reality.[10, p. 233]

Fromm writes with a moving simplicity of aspects of our life which are seldom, if ever, acknowledged in classical psychoanalytic literature:

. . . death confronts us with the inevitable fact that either we shall die before our loved ones or they before us. . .[24, p. 201]

Psychoanalytic literature concerning grief tends to limit itself, by contrast, to a consideration of the grief which one feels over having lost a loved one; how often do we see mention of the grief one feels at the prospect of one's own death, or that of a loved one? In the latter two instances, we turn too quickly to a search for unconscious suicidal feelings or unconscious death wishes.

There is one aspect of psychoanalytic literature, beyond its long-standing emphasis, pro or con, concerning a hypothetical death instinct; beyond its time-honored focus upon the early years of life; and beyond its preoccupation with the symbolic, as distinct from the real, aspects of "death," which has limited the ability of this literature to do justice to the subject of death. This aspect consists in a limitation which psychoanalytic literature shares, inherently, with all literature: It must rely upon verbal communication to deal with a subject which is of extraordinary complexity, and of a complexity which very possibly lends itself better to various forms of nonverbal communication than to communication in the medium (the highly abstract and reality-segmentalizing medium) of words.

The fact that all men must die is a simple fact; but for each one of us the feeling-ramifications which flow in response to this fact are probably among the most complex, if not *the* most complex, that we can possibly experience. It may well be that the more mature a person is, the more complex are his reactions to this simple and universal fact of human existence; and surely the fabric of a person's reactions will comprise a uniquely individual pattern, different from that of any other human being. Certainly such complexity is too much to be grasped by the very immature ego of a child, or by the impaired ego of a psychiatrically deeply-ill adult. Here, the writer is reminded of a beautiful statement made by the Irish short story writer, Frank O'Connor,[25] near the end of a story concerning a deeply conflictual situation in his own boyhood. He says:

"... For the first time I realized that the life before me would have complexities of emotion which I couldn't even imagine."

A deeply schizophrenic woman who is unusually talkative has shown, many times, the following phenomenon. As the author starts to leave her room at the close of the therapeutic session, her speech becomes more rapid and, within the space of less than a minute, she recounts as many as a dozen incidents in the past involving as many different persons she has known, each incident involving a single predominant affect: One or more of the incidents clearly involve anger, others involve grief, others involve contempt, and so on. It was only after the writer had seen this phenomenon a number of times that he realized that this is her indirect way of expressing the complexity of her feelings, probably for the most part unconscious feelings, concerning the single *here-and-now* situation of impending separation from the analyst. The writer thinks it accurate to describe her ego as being, at present, too impaired to enable her to tolerate, within awareness, the complexity of feelings, among which are rage, grief, contempt, and so on, aroused by this stressful here-and-now situation. Instead, the feeling-complex is experienced in its separate ingredients and is spread, moreover, over "target-persons" from various situations in past years. Thus instead of her being able to experience this as, "I feel rage and grief and contempt (etc., etc.) toward you right now, as you are leaving," she apparently feels it as follows: "I was angry at A in that situation four years ago,

and I was grieved in that situation with B two years ago, and I was filled with contempt in that situation with C six years ago, and. . ."

This phenomenon has struck the writer as being very similar to that which is reported in the literature as occurring in the experience of persons who are face to face with imminent, and apparently inescapable, death: an extremely rapid reviewing, before the mind's eye, of events from their whole remembered lives. Eissler,[13] discussing Oscar Pfister's[26] paper on this subject, says that "surprisingly many informants report having had the feeling that their whole lives passed in stage-like manner before the inner eye . . ."[13, pp. 181-182] Eissler suggests that this represents the struggle to create a new ego, in order to meet the supreme challenge of apparently certain and imminent death. Another way of looking upon this phenomenon—a view which would not exclude that of Eissler—is that this supreme moment of personality-stress calls forth emotions which are too intense and too varied to be experienced simultaneously, as having to do with the here-and-now situation. This is precisely analogous to the writer's schizophrenic patient's mode of experiencing the impact of the end-of-the-session separation from her therapist.

It seems to the writer very possible that such complex emotions may be conveyed better by nonverbal media than by the media of words, to which psychoanalytic literature must, of course, limit itself; a symphony, for instance, may help us to feel the complex meanings of our own personal anticipation of death, far more adequately than any words could express. Langer[10] expresses her conviction that various forms of artistic expression—music, poetry, and other art forms—can express emotions which our much-vaunted words cannot communicate:

> . . . Just as words can describe events we have not witnessed, places and things we have not seen, so music can present emotions and moods we have not felt, passions we did not know before.
>
> . . . A composer not only indicates, but *articulates* subtle complexes of feeling that language cannot even name, let alone set forth . . .[10, p. 180]
>
> . . . art—certainly music, and probably all art—is formally and essentially untranslatable. . .[10, p. 190]
>
> Because the forms of human feeling are much more congruent with musical forms than with the forms of language, music can *reveal* the nature of feelings with a detail and truth that language cannot approach. . . .
>
> . . . Liszt warned specifically against the practice of expounding the emotive content of a symphonic poem, "because in such case the words tend

to destroy the magic, to desecrate the feelings, and to break the most delicate fabrics of the soul, which had taken this form just because they were incapable of formulation in words, images or ideas."[10, p. 191]

... I believe the "aesthetic emotion" and the emotional content of a work of art are two very different things; the "aesthetic emotion" springs from an intellectual triumph, from overcoming barriers of word-bound thought and achieving insight into literally "unspeakable" realities; but the emotive content of the work is apt to be something much deeper than any intellectual experience, more essential, pre-rational, and vital, something of the life-rhythms we share with all growing, hungering, moving and fearing creatures: the ultimate realities themselves, the central facts of our brief, sentient existence.[10, p. 211]

Concerning poetry, Langer points out:

... though the *material* of poetry is verbal, its import is not the literal assertion made in the words, but *the way the assertion is made*, and this involves the sound, the tempo, the aura of associations of the words, the long or short sequences of ideas, the wealth or poverty of transient imagery that contains them, the sudden arrest of fantasy by pure fact, or of familiar fact by sudden fantasy, the suspense of literal meaning by a sustained ambiguity resolved in a long-awaited key-word, and the unifying, all-embracing artifice of rhythm. ...[10, p. 212]

In connection with the last of these quotations from Langer, one sees that poetry, though couched in words, does indeed serve more adequately to symbolize various ingredients of our complex feelings concerning the inescapable prospect of death, than do words in the form of prose. The author, at least, is unacquainted with any works of prose which so fully convey the fear of death as does Keats' sonnet, *When I Have Fears*:[27]

When I have fears that I may cease to be
Before my pen has glean'd my teeming brain,
Before high piled books, in charact'ry,
Hold like rich garners the full-ripen'd grain;
When I behold, upon the night's starr'd face,
Huge cloudy symbols of a high romance,
And think that I may never live to trace
Their shadows, with the magic hand of chance;
And when I feel, fair creature of an hour!
That I shall never look upon thee more,
Never have relish in the faery power
Of unreflecting love!—then on the shore
Of the wide world I stand alone, and think
Till Love and Fame to nothingness do sink.[27, pp. 153-154]

Or consider the courage of Robert Browning's *Prospice*:[27]

Fear death?—to feel the fog in my throat,
The mist in my face,
When the snows begin, and the blasts denote
I am nearing the place,

. . . . . .

Where he stands, the Arch Fear in a visible form,
Yet the strong man must go;

. . . . . .

I would hate that death bandaged my eyes, and forebore,
And bade me creep past.
No! let me taste the whole of it . . .[27, pp. 245-246]

Or there is the raging protest of Dylan Thomas' plea to his aged, mellowed father, in *Do Not Go Gentle Into that Good Night*:[28]

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.*[28]

. . . . . .

Or there is the longing for death, as epitomizing peace, which is contained in Robert Louis Stevenson's *Requiem*:[27]

Under the wide and starry sky,
Dig the grave and let me lie.
Glad did I live and gladly die,
And I laid me down with a will.

This be the verse you grave for me:
Here he lies where he longed to be,
Home is the sailor, home from sea,
And the hunter home from the hill.[27, pp. 299-300]

Discussion

What has been said in this paper concerning the effectiveness of intrapersonal and interpersonal integration in enabling us to face the prospect of death—one's own individual death, as well as that of one's loved ones—seems to the writer to be equivalent to what certain existentialist writers have said in a different terminology. For example, Binswanger, and in one instance Jaspers, are paraphrased by Weigert[15] as saying, concerning love,

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. . . Here is no longer the I threatened by the loss of self in the struggle for existence, nor the you endangered by isolation: I and you are merged in the we, togetherness. This we-ness is experienced as the most triumphant security and certainty of existence there is. . . .

The existential certainty of Love triumphs even over death. Not that it takes anything away from the intensity of grief. But there is not the bitterness which follows the ultimate termination of an ambivalent relation. . . . The nature of Love is above all separations, since the selfhood of you is so deeply imprinted in me, just as mine is in yours, that the security of we-ness endures. Only an individual can die, the we-ness remains intact. This we-evidence meets life with that "deep serenity, which dwells at the bottom of the unextinguishable grief" [Jaspers].

And Tillich[16] emphasizes that man's sense of being an integral part, not only of humankind, but of the universe as a whole, enables one to conquer the anxiety concerning death (a point which has been elaborated upon by the present writer elsewhere):[29]

. . . The anxiety of fate is conquered by the self-affirmation of the individual as an infinitely significant microcosmic representation of the universe.[16, p. 120]

. . . Even loneliness is not absolute loneliness because the contents of the universe are in him.[16, p. 121]

Fromm[24] has described our culture as containing many features which interfere with the individual's developing such a sense of wholeness, and one may compare the writer's description of the schizophrenic's inability (partly by reason of his non-integration upon both intrapsychic and interpersonal levels) to face death's inevitability, with Fromm's following remarks:

. . . modern man exhibits an amazing lack of realism for all that matters. For the meaning of life and death, for happiness and suffering, for feeling and serious thought. He has covered up the whole reality of human existence and replaced it with his artificial, prettified picture of a pseudo-reality, not too different from the savages who lost their land and freedom for glittering glass beads. . . .

Another factor in contemporary society . . . is destructive to reason. Since nobody ever does the whole job, but only a fraction of it, since the dimension of things and of the organization of people is too vast to be understood as a whole, nothing can be seen in its totality. . . .[24, pp. 170-171]

. . . man can fulfill himself only if he remains in touch with the fundamental facts of his existence, if he can experience the exaltation of love and solidarity, as well as the tragic fact of his aloneness and of the fragmentary character of his existence. If he is completely enmeshed in the routine and in the artefacts of life, if he cannot see anything but the man-made, com-

mon-sense appearance of the world, he loses his touch with and the grasp of himself and the world. . . . [24, p. 144]

The author surmises that, insofar as an individual is a whole person intrapsychically, and able to participate wholly in his relatedness with other persons as well as with his nonhuman environment, he does not react to this subject of life's finitude as a separate nucleus of feelings in itself. It constitutes, rather, an ingredient of, or background for, all his life-experiences. Insofar as we can dare to keep ourselves open to the recognition of the finitude of our lives, this recognition can make our pleasurable experiences more precious, our despair supportable, our work a matter not of resented drudgery but of wholehearted dedication, and so on. Just as one can be a truly whole person only through facing this harshest aspect of reality, the inevitability of death, so, too, can one become able to live fully, only if one lives in the light of this recognition.

The writer believes others will find, as he has, that the more one explores this whole subject of the psychological import of life's finitude—its import to human beings, whether schizophrenic or nonschizophrenic—the more one's personal philosophy of life is deepened and enriched. And we know how essential it is, for one who conducts psychoanalysis and psychotherapy, to be deeply sure that life is meaningful and worth while—even a life which at times seems meaningless and a life which ends, inescapably, in death.

Summary

The ostensibly prosaic fact of the inevitability of death is, in actuality, one of the supremely potent sources of man's anxiety, and the feeling-responses to this aspect of reality are among the most intense and complex which it is possible for us to experience. The defense-mechanisms of psychiatric illness, including the oftentimes exotic-appearing defenses found in schizophrenia, are designed to keep out of the individual's awareness—among other anxiety-provoking aspects of inner and outer reality—this simple fact of life's finitude. Various characteristics of our culture serve to maintain our obliviousness to this fact of inevitable death, and the psychodynamics of schizophrenic illness, in particular, serve as strong defenses against the recognition of it. Although the earliest roots of schizophrenia may antedate the time in the individual's life when death's inevitablity tends to confront him, it

is the writer's impression that this particular deeply anxiety-provoking aspect of reality is one of the major threats which the schizophrenic process is serving to deny.

Chestnut Lodge
500 W. Montgomery Avenue
Rockville, Md.

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AMARIAH BRIGHAM, ISAAC RAY AND SHAKESPEARE

BY IRVING I. EDGAR, M.D.

I

Drs. Amariah Brigham, and Isaac Ray are deservedly well known as important figures in the history and progress of psychiatry. Both were medical superintendents of famous psychiatric hospitals. Both are numbered among the 13 original founders of the Association of Medical Superintendents of American Institutions for the Insane, which developed into our present American Psychiatric Association. Both held high office in this association, Brigham being vice president in 1848 but dying in 1849 before he could attain to the presidency, while Ray served in both capacities between 1851 and 1859. Both traveled extensively for further psychiatric education through the medical centers of Europe. Both contributed much to the psychiatric literature of their day, Amariah Brigham actually being the founder and first editor of the *American Journal of Insanity,* forerunner of the present *Journal of The American Psychiatric Association,** and Isaac Ray publishing many articles in the issues of that journal as well as elsewhere. Both added much to the advancement of American psychiatry.[1]

What is less well known and certainly of more than mere passing interest is the fact that both men also occupy a place in the history of Shakespearean criticism. Being psychiatrists with broad educations and wide humanistic interests, both men focused on Shakespeare's dramas in terms of psychopathology. And their contributions, both in this field of psychiatry and that of Shakespearean criticism first appeared in the *American Journal of Insanity.*

Brigham wrote his commentary on Shakespeare's characters in a paper entitled "Insanity—Illustrated By Histories of Distinguished Men and by the Writings of Poets and Novelists." It appeared as the first formal article in the first issue of the *American Journal of Insanity* in July 1844, and ran from pages 9 to 49, pages 27 to 41 being devoted exclusively to Shakespeare's dramas. Ray entitled his paper, "Shakespeare's Delineations of Insanity," and it appeared in the *Journal,* April 1847, and ran extensively—from pages 289 to 332. It is interesting to note that this paper,

*And of THE PSYCHIATRIC QUARTERLY.

somewhat enlarged, was later included in Ray's then very important book, *Contributions to Mental Pathology,* which appeared in 1873;[2] and that although Ray gives historical credit for papers in this field to several commentators who were psychiatrists, he does not mention Brigham's original paper which appeared earlier. Whether this was a measure of Ray's critical evaluation of Brigham's work, or represents a facet of envy of a colleague, or was merely an oversight is a matter for interesting speculation.

Be that as it may, it is factually true that while there were a few previous publications in this field of psychiatry and Shakespearean criticism, these were by laymen and mainly in Europe, so that Brigham's paper was the first of its kind to appear in America (1844), while Ray's contribution (1847) was the second to be published here—both in the *Journal of Insanity.*

Drs. Brigham and Ray then, may be considered the first psychiatrists in America to write in this area of Shakespearean criticism. They are the pioneer commentators in this country, who dealt with the psychiatric aspects of Shakespeare's dramas, leading the way for many others who were to follow.

However, both these men were but children of their century, living in the frame of reference of their own times and molded by the streams of thought flowing through the intellectual atmosphere of their day. They succumbed only too readily to the cult of Shakespeare-idolatry then in vogue, and added much to its influence in their particular field of criticism. This idolatry caused these two psychiatrists, among many others, to raise Shakespeare to a most false pinnacle of special knowledge in psychopathology.

Thus Brigham, referring to Shakespeare's "remarkable ability, ... accuracy, ... immensity and correctness of his knowledge" in delineating insanity says, "There is scarcely a form of mental disorder he had not alluded to and pointed out the causes and treatment" and he "seems to have understood all its varieties and all its causes ..." Further, "his knowledge of insanity was not only great and varied ... but his views were very far in advance of the age in which he lived." He writes of "the mental disorder of Hamlet [as] most exquisitely drawn ... finely portrayed, ... a full history of a case of insanity"; and he considers Lear's disorder "a genuine case of insanity from the beginning to the end ... a real case ... correctly reported ... a faithful history of a case of senile insanity." Brigham goes on to prove point by point that

Shakespeare "believed the following facts, all of which were in advance of the general opinions of his age and are now deemed correct:

"1. That a well formed brain, a good shaped head, is essential to a good mind.

"2. That insanity is a disease of the brain.

"3. That there is a general and a partial insanity.

"4. That it is a disease which can be cured by medical means.

"5. That the causes are various, the most common of which he has particularly noted."

He concludes by saying, "In this extensive establishment [New York Lunatic Asylum, Utica, of which he was superintendent] are all the insane characters described by Shakespeare."[3]

In similar vein, does Ray raise Shakespeare to undeserved pinnacles of special knowledge in psychopathology. Speaking of "... the extraordinary merit of Shakespeare's representations of insanity" and of "the unapproachable preeminences of Shakespeare in the delineation of insanity," he affirms that Shakespeare's "knowledge ... could hardly have been expected from any but a professional observer," and "... was in advance of his own and succeeding generations..." He says further, that "in the pages of Shakespeare are delineations ... of insanity that may be ranked with the highest triumphs of their masterly genius, ... greatly in advance of the current notions of his own and perhaps the present times."

Referring specifically to *King Lear,* Ray says, "that the development of the early stage of Lear's insanity, or its incubation, as it is technically called, is managed with masterly skill ..." Referring to the scene on the heath between Lear, Edgar and the fool he exclaims, "... who can finish this scene without feeling that he has read a new chapter in the history of mental disease of most solemn and startling import?" Pointing to Edgar's feigned insanity in the same scene, he remarks, "The management of Edgar's simulation, strikingly evinces the accuracy and the extent of Shakespeare's knowledge of mental pathology." Speaking of the skill of the poet's delineation of Hamlet's insanity, he refers to it as a "great skill ... founded on what would seem to be a professional knowledge of the subject." He considers Shakespeare as having "a most thorough mastery of the phenomena of insanity and the most consummate skill in ... displaying them in action"; and as

"... unfolding many a deep truth in mental science." With regard to the treatment in vogue in his own times, Ray comes to the conclusion: "Would that we were able to say that courts of our own times studied the influence of insanity upon human conduct by the light of Shakespeare ... and of nature than of metaphysical dogmas and legal maxims."[4]

As already noted, both Brigham and Ray are viewing Shakespeare's psychiatric knowledge in a very uncritical and unhistorical way. They fail to place him in the milieu in which he moved, the historical horizons by which he was limited. Hence the picture we have is distorted and false and remains but bardolatrous rhetoric. It can readily be shown that Shakespeare's apparent knowledge in the broad field of medicine and psychiatry was actually but a reflection of the general medical knowledge current at the time.[5]

II

Even a superficial perusal of the intellectual atmosphere that Shakespeare breathed readily explains much more simply and satisfactorily than do Brigham and Ray the psychiatry in his dramas. This leads to one conclusion: Shakespeare, in this respect, was only a child of his own age and not ahead of it, and, he reflects only the ideas and conceptions current in Elizabethan England, the thought-patterns of which were woven by him into words of such unforgettable dramatic and poetic language as his plays really are.

In the first place, Brigham quotes three passages to show that the poet referred to low foreheads disparagingly, and hence that he recognized "the excellence of a high forehead, and that a well-formed brain is essential to a good mind."[3] Presto! He comes to the conclusion that on this basis Shakespeare was "in advance of the general opinions of his age." As a matter of fact, all this was common belief for centuries and certainly during Shakespeare's day. Frequent reference to this can be found in the literature of the period. Thus Andreas Laurentius, a famous physician of the times, in his *Discourse on The Disease of Melancholie* (1599), a very popular book in Shakespeare's day, writes: "... that such as have large and high foreheads are of pleasant imagination and that such as in whom these two eminences are wanting are blockish, without imagination, and without memorie."[6] Burton in his *Anatomy of Melancholy* (Memb. I, subs. 4) considers that "much hair

on the brows . . . and a little head argues natural melancholy."[7] It can be shown that many other writers of the period have similar references.

Second, Brigham and Ray particularly stress the fact that Shakespeare refers "to insanity as a disease of the brain," and that on this basis he was "in advance . . . of his age." Here, too, an even superficial view of the literature of Elizabethan England would have indicated readily that most intelligent laymen, let alone the physicians of the times, knew that "insanity" had its source in the brain. Vicary, chief surgeon of St. Bartholomew's Hospital (1548-62), writes in his *Anatomie of the Bodie of Man* that ". . . when . . . the Brayne is too drye or too moyst . . . then followeth feebleness of the wittes . . ."[8]

Burton, writing "Of the part affected" in melancholy (insanity) states that ". . . the brain must needs primarily be misaffected as the seat of reason." Laurentius and Timothy Bright[9] express similar views.

Furthermore, many of Shakespeare's contemporary dramatists express similar conceptions. John Ford in *The Lover's Melancholy* (III, 1), Massinger in *A New Way to Pay Old Debts* (V, 1), Middleton in *The Changeling* (I, 2), and others all place the brain as the seat of insanity. It was indeed a platitude of the times and not the special possession of Shakespeare.

This also holds true of the assertions and implications by Brigham and Ray that Shakespeare's "knowledge of insanity was . . . far in advance of the age in which he lived,"[3] and ". . . of his own and succeeding generations,"[4] because, in their views, Shakespeare believed that "insanity is a disease which can be cured by medical means."[3] This was in contradistinction supposedly to those who would use manacles, whips, keep the insane in dark dungeons, pray to expel, or try to charm or exorcise, the demons possessing the insane.

In the first place, side by side with passages in his dramas pointing toward humane treatment of the insane, Shakespeare has numerous passages indicating general acceptance of the common, most often inhumane, treatment. He says,

> Love is merely a madness; and I tell you *deserves*
> as well a dark house and a whip as madmen do
> *As You Like It*, III, 2, 420.

> Both man and master are possess'd...
> They must be bound and laid in some dark room
> *Comedy of Errors,* IV, 4, 95.
>
> Not mad, but bound more than a madman is;
> Shut up in person, kept without my food
> Whipt and tormented...
> *Romeo and Juliet,* I, 2, 54.
>
> If 'gainst yourself you be incensed, we'll put you
> (Like one that means his proper harm) in manacles
> *Coriolanus,* I, 9, 56.

But Shakespeare goes even further than this when he actually derides those who

> Would give preceptial medicine to rage—
> Fetter strong madness in a silken thread
> Charm ache with air and agony with words
> *Much Ado About Nothing,* V, 1, 24

And again in *Twelfth Night* (III, 4) when Fabian advises in the treatment of Malvolio's madness:

> No way but gentleness; gently, gently; the fiend is rough and will not be roughly used

Sir Toby rants:

> ...what, man! 'tis not for gravity to play at cherry-pit with Satan: hang him, foul-collier!

No indeed, Shakespeare did not rise above his times in advocating humane treatment for the insane.

But even if it were specifically true that Shakespeare did advocate particularly kind treatment for the insane, this most certainly would not place him ahead of his age. Any standard history of medicine of that time could have revealed the fact that Dr. Felix Platter (1563-1614) advocated and fought for mild treatment of the insane. Moreover, even a most casual acquaintance with Elizabethan literature would indicate that such treatment was common and general knowledge. Bartholomew's *De Proprietatibus Rerum* was a popular encyclopedia of medicine written by a nonphysician in the thirteenth century, printed and reprinted many times until the seventeenth century, considered "the most read book after the Bible down to the middle of the sixteenth century... [and] the favorite reading of Shakespeare and a number of the Elizabethan writers."[10] In this favorite "popularization of medicine" surprisingly, not only "is... there... not a word

about possession by spirits" as a cause of insanity, with the usually expected concomitant treatment, but it is said that "the insane must be bound so that they hurt not themselves and others, their environment must be changed, they must be gladded with instruments of music and some deal occupied," in addition to "purging and electuaries and feeding them well and refreshing them."[10] Similarly Andrew Boorde in his popular *Dyetery of Helth* (1542), advocates the confinement of the insane in dark rooms devoid of objects with which they might harm themselves. He would also be gentle toward them and provide them with a good diet.

Laurentius also, in his then well-known *Discourse of the Disease of Melancholie* (1599) advocates, in the treatment of the insane, a "good order of dyet," "an ayre as is temperate," "claret wine ... indifferently delaied," "sleepe, the meanes to doe it," "moderate exercise ... in pleasant and delightsome places ... with rest ... oft," "Musicke in all melancholike diseases," "baths," "Faire words and cunning speeches" in addition to "eigher letting of bloud, or purgation of numerous types," "many sorts of opiates" for "sleepe," etc., etc.

Needless to say, Burton, too, and in much greater elaboration, advises all these means of treating melancholy "the disease of the brain," in addition to much else.[7]

Furthermore, one need only consult some of Shakespeare's contemporary dramatists to realize even more fully that the poet was not unique in his treatment of madness. Thus Philip Massinger in *A Very Woman* (III, 2) and *The Virgin Martyr* (IV, 1), Fletcher in *The Two Noble Kinsmen* (IV, 2), Ford in *The Lover's Melancholy* (1628) and others—all enact humane treatment for the insane, even to a greater degree than Shakespeare.

And so one sees that "To produce sleep and to quiet the mind by medical and moral treatment, to avoid all unkindness ... to guard against ... a relapse ..."[3]—words which Brigham applies to Shakespeare's portrayal of the treatment of the insane, as if humane treatment were the poet's exclusive discovery—really describe one of the accepted forms of treatment of certain types of madness in the Elizabethan period.

Then, too, that Shakespeare was "in advance of the general opinions of his age"[3] because he knew the causes of insanity to be various, and that there are several varieties of insanity as elabor-

ated by Brigham, also turns out to be an invalid assertion. Aside from the exhaustive dissertations on the subject by Bright, Burton, Laurentius and others, to which Shakespeare certainly had access, and which refute this idea that he was ahead of his time, one finds dramatists contemporary with Shakespeare portraying such varieties of madness with even greater fidelity, though perhaps with less literary art. Thus Ben Jonson in *Epicene* (IV, 2) writes of "insomnia furor, vel ecstasis melancholico, that is eggressio, when a man ex melancholico evadit, fanaticus . . . But he may be but 'phreneticus,' yet, mistress, and 'phrenesis' soney debrum or so." Ford in the *The Lover's Melancholy* (III, 1) writes of "Ecstasy, Fantastic Dotage, Madness, Frenzy, Rapture," as varieties of insanity. The various mad characters with their varying degrees of madness in the dramas of Shakespeare and the causes thereof including melancholy, love, watchfulness, irritation, jealousy, worry, heredity, etc., can be easily matched in the dramas of his contemporaries.

Brigham, Ray and many others following their lead certainly allowed their emotional bardolatry to hypnotize their reason in their studies on Shakespeare; but, as already remarked, they followed but the trend of their times and their importance here lies in their having thrown a spotlight on Shakespeare's "mad characters" in terms of psychopathology, thereby leading the way in the newer evaluation of the poet for their own time and in their own special field. No more perhaps, can be expected of anyone.

710-12 Maccabees Building
Detroit 2, Mich.

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THE PROBLEM OF THE PATHOGENESIS OF SCHIZOPHRENIA*

BY YE. A. POPOV, M.D.

A large number of works have been dedicated to the manifestations of schizophrenia. The collected factual material is diversified, variegated and even contradictory. Undoubtedly a demand has arisen for a presentation of some points of view in terms of which one might attempt to impose some order upon, and bring into a unified system, the material which we at the present time have at our disposal. This is the sort of attempt which we wanted to make in the present article, in developing a concept which was advanced by us as early as 1946.[1-3]

For a fairly satisfactory solution of the task, it is essential to observe a number of conditions, and to concede a number of limitations, which make the problem more precise.

The contradictions among the findings obtained by a number of authors depend mainly on their different understandings of what they designate by the term schizophrenia. Schizophrenia as an independent nosological entity has not always been differentiated with sufficient clarity from schizophrenoid disturbances, which are similar in their clinical manifestations but which are of different origins. One must take into account both the Soviet authors and the foreign literature for an understanding of schizophrenia as a syndrome. Hence, into the framework of this diagnostic designation, various dissimilar diseases are forced; and naturally, the studies of them yield variegated results which in a number of respects are conflicting. Even in cases when the study is limited to schizophrenia in the strict sense of the word, sight is not infrequently lost of the differences determined by the stages of the disease, the acuteness or chronicity of the course, the presence of secondary complicating symptoms, individual peculiarities of the organism and other factors causing the diversification of the variations on the background of the basic canvas—the schizophrenic process.

It is necessary to introduce a strict distinction between etiology and pathogenesis. It must be recognized that the etiology of

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schizophrenia, i.e., the causes giving rise to this disease, remains still unknown to us. As regards the pathogenesis, i.e., the mechanisms causing the development of the symptoms, of the manifestations of the disease, there has been gathered a large amount of factual material, and some partial generalizations have been drawn in this direction. In the ensuing exposition, we shall confine ourselves to the problems of pathogenesis.

In an attempt to clarify, from a general point of view, the clinical manifestations of schizophrenia it is necessary to try to embrace, insofar as possible, all the symptoms of this disease which are observed with sufficient clarity and constancy, and not to confine one's self to any one group of them. Thus, Hoskins,[4] discerning in schizophrenia the consequences of unusual "immaturity" of the organism and the resulting inadequacy of adaptation, depends primarily upon the facts regarding disturbances of the homeostatic functions. Delay and Cloutier[5] and others, applying Selye's concepts to their understanding of the mechanisms of the pathology and the therapy of schizophrenia, proceed basically from an analysis of the neurovegetative and humoral deviations. The psychic disturbances, which are, beyond a doubt, the most important manifestations of the disease, are not allotted enough attention in all this. On the other hand, a number of authors, concentrating their attention on the disruptions in higher nervous activity, i.e., the psychic disturbances, neglect the findings relating to the conditions of the internal organs, metabolism, etc.

But is there a possibility, even in observing all the limiting conditions pointed out in the foregoing, of connecting the psychic and the "somatic" manifestations of schizophrenia? Can one represent them as parts of one single syndrome? For an answer to this question, we shall look, in a sequential examination, at the psychic disturbances in schizophrenia, at the vegetative abnormalities and at certain peculiarities of metabolism, and finally we shall compare the findings obtained.

With respect to the psychic manifestations of schizophrenia, one can consider it established at the present time that they are caused by various inhibitions in the cerebral cortex. This viewpoint expressed by I. P. Pavlov, served as a guide for a number of studies by Soviet psychiatrists and received full confirmation. The variegated clinical pictures, observed in schizophrenia, are determined by differences in the depth and degree of dissemina-

tion of the inhibitory process in the higher divisions of the brain. This explanation is so generally accepted at present that it is not necessary here to expound or argue it in more detail. This was done in part by us elsewhere.[6-7] Here we shall confine ourselves to recalling certain basic positions. Mutism and immobility of the patients with the catatonic form of schizophrenia are natural forms of expression of cortical inhibition. The distorted reactions of these patients—negativism or reaction only to weak stimuli and not to strong ones—are caused by the hypnotic phases, ultraparadoxical and paradoxical. The heightening of muscular tonus with passive extension of the muscles, thereby resisting changes in posture; waxy flexibility; fetal poses; forceful clutching; imitative and body-deforming reflexes must be regarded as manifestations of different subcortical reflexes which, under ordinary conditions, are suppressed by impulses deriving from the cortex and are released from such control when the cortex is inhibited. Proof of this is found in the fact that by strengthening the stimulatory process in the cortex with the aid of caffeine, cocaine, etc., one can remove temporarily the symptoms described. The dissemination of inhibition in the subcortical formations also appears to explain the so frequently observed disruption of a number of unconditioned reflexes—vascular, galvanic-skin, orientating, rotating and caloric nystagmus, and others. The role of inhibition in the origin of these disturbances is confirmed by their instability. In studies over a period of several days, we see that one and the same group of reflexes now disappear, now appear again, now are weakened, now strengthened, etc. Observations of the phase reactions (balancing, paradoxical and so forth), upon the eliciting of these reflexes, testify to the fact that such variations depend upon inhibition.

Typical catatonic stimulation—uncommunicative, and lacking self-guidance and physical control in a manner reminiscent of the movements in extrapyramidal hyperkinesia—is explained by the loss of inhibition and positive induction in divisions of the brain lying beneath the cortex, "by the turbulence of the subcortex" in I. P. Pavlov's expression. The correctness of such a hypothesis is confirmed by the fact that large doses of caffeine diminish the state of catatonic stimulation. The symptoms characterizing hebephrenia were related by Pavlov to the release from inhibition of the subcortex. The connection of schizophrenic hallucinations with

the state of partial inhibition (balancing and paradoxical phases) in the cortex of the brain was clarified by us,[8] and thus we shall confine ourselves to the indications of these findings.

As regards the most characteristic and important manifestations of schizophrenia—the unique changes in mentation—these have already been touched upon by a number of authors (Bleuler, Kurt Schneider, Regis, and others), with attention given to their similarity to the mental phenomena in dreams. This similarity acquires great significance if one takes into account that in sleep, precisely as in schizophrenia, a state of excess inhibition prevails in the cerebral cortex. Thus one could say that similar physiological states lead to similar changes in the course of mentation. In a number of works, [9-10] we have attempted to show that in the two conditions similar pathophysiological mechanisms are operative, primarily a disturbance of the more difficult forms of differentiation, in consequence of which words or ideas which are similar in some respects replace each other, imparting to the speech or judgments of the patient an unreasoning character. Such a view of the nature of schizophrenic mentation may be confirmed by a number of observations on the effects of medications which excite the stimulatory process in the cortex of the brain. We have noted, not infrequently, that under the influence of large doses of caffeine, cocaine or phenamine the disruptions of schizophrenic thought can temporarily be brought into some order. The phenomenon was observed with remarkable clarity and regularity, in the investigations of O. N. Dokuchayeva.[11] In associative experiments the reactions of the patients with schizophrenia, as is known, are characterized by a prolonged latent period and an absence of normal rational connections between word-stimuli and responses.

By using appropriate doses of caffeine, O. N. Dokuchayeva succeeded in eliciting in 54 of 60 patients with schizophrenia a disappearance or diminution in the number of pathological word associations, and their replacement with normal ones, in what were, as a rule, single shortenings of the latent period. If too large doses of caffeine are used, the associative processes are made worse. This phenomenon is explained by the fact that an excessively strong stimulus (in this case, caffeine) causes excessive inhibition, whereas a more moderate dose causes stimulation. Speaking of the similarity between sleeping persons and patients with schizophrenia, it should be noted that in both cases we may observe

the phenomenon of unusual "autism": The reaction to stimuli originating in the surrounding environment is weakened, but, in this weakening, there is a predominance of reactions to the internal and trace ("forms of recollection") stimuli. These apparently are the physiological bases of the "immersion in dreams" in the case of the sleeper, and of the "departure into the world of internal experience" in the case of the schizophrenic.

Thus, all the fundamental psychic manifestations of schizophrenia can be regarded as the result of inhibition "in different stages of dissemination and intensity" in the schizophrenic; according to I. P. Pavlov, it is an inhibition which embraces the cortex of the brain and extends to one or another level of the subcortical functions.

As regards the status of the vegetative nervous system in schizophrenia, we came across, in acquainting ourselves with the literature on this question, significant differences of opinion. The authors of the older works remarked that in the catatonic form of schizophrenia, as a rule, one could observe an enhancement of diaphoresis, of salivation, of greasiness of the face, reduction of pupillary size, tendency to dilatation of the skin vessels (acrocyanosis and acroerythrosis), bradycardia, and low blood pressure. From this, naturally, the conclusion was drawn that there is a predominance of tonus of the parasympathetic division, at least in catatonic schizophrenia.*

Further accumulation of material has led to significant divergencies of opinion. The conclusions to which various authors have come have been, on occasion, in direct opposition. However, with more careful analysis of the separate works, one can discover the source of such a diversity of points of view. It is impossible not to note that many investigators both in collecting factual material and in analyzing it have let errors creep in which confuse the actual state of things. Let us indicate here only a few such errors.

No distinction was made [by such an investigator] between tonus and reactivity. The strength with which a given apparatus reacted to the stimulus applied to it was regarded as an indicator of the tonus of this apparatus. In actuality, such a correspondence exists only within certain average limits, beyond the bounds of

*As regards the sweat glands, although they receive fibers from the sympathetic nerves, they are closer in their physiologic properties to the cholinergic (parasympathetic) system: Atropine suppresses sweating, whereas pilocarpine, on the contrary, sharply increases it, etc.

which there is a separation between tonus and reactivity. Thus, for instance, in sharply expressed bradycardia (sometimes reaching a rate of 40 beats a minute or less, in schizophrenics) pressure on the eyeballs may not elicit a further slowing of the pulse or may elicit it only to a very slight degree. This mechanism, noticed and generalized by Wilder in the form of the "law of initial values," has been completely disregarded by many investigators. From what has been said, it is clear that conclusions based only on an evaluation of vegetative reflexes may be quite erroneous.

Sufficient attention has not been given in studies to the state of the patient. But, indeed, it is perfectly obvious that, preceding motor stimulation or prolonged rest, the emotions of joy or of sorrow are reflected in the state of the vegetative system, and create superposed layers which make the distinguishing of the fundamental background difficult. It is especially easy to overlook such additional factors in patients in the state of catatonic stupor. G. M. Ekelova-Bagaley,[12] removing catatonic dumbness with the aid of cocaine, discovered that the patients in whom there was an increase in the pulse rate were experiencing sorrow, anxiety, or terrifying hallucinations, but these could only be revealed following the administration of cocaine and establishment of verbal contact with the patients.

Evaluating the interrelationships of the sympathetic and parasympathetic divisions, no distinction has been made between absolute and relative strengths of tonus. Even a weakly tonic division may predominate if the one opposing it is still weaker. Comparable relations may be discovered also in the situation in which there are unequal enhancements of the tonus of both divisions of the vegetative nervous system.

The difference has been disregarded between primary and secondary effects of vegetative dislocations caused by one or another agent. From the following examples, it is apparent what kind of relationships may build up here. The injection of adrenaline causes a quickening of the pulse and a simultaneous increase of the blood pressure. If the latter reaches a significant level, compensatory reflexes arise from the walls of the aorta to produce a slowing of the pulse and a dilatation of the vessels, particularly of the abdominal cavity and the skin. The first reactions sometimes survive the onset of the second. Thus, at a given moment, elevation of the blood pressure may be combined with a slowing of the

pulse, and, if attention is not given to the sequence of phenomena, contradictory impressions of the sympathicotonic dislocations in one area, and of the parasympathicotonic in another, will be gained.

Certain authors have come to conclusions about the status of the vegetative nervous system on the basis of studies of too small a number of patients, sometimes of only a few individuals. Instead of making a many-sided study of the vegetative nervous system, they have been content with two or three isolated tests (and sometimes with only one). Instead of systematic investigations repeated from day to day over the course of a long period, they have limited themselves to single or interrupted studies—"from case to case." It is completely understandable that the impress of chance lies on data thus acquired.

If, proceeding from what has been said, one makes appropriate corrections, it is discovered that in actuality the divergences of the various authors are fewer than they would seem at first glance. The most careful and methodical studies, conducted in a manner that is beyond reproach, testify to the predominance of parasympathetic tonus.

Such testimony is supplied by findings gathered in our clinic over the course of a number of years. V. Ye. Litvinova,[13] systematically studying the state of the vegetative nervous system in 135 patients with various forms of schizophrenia (18,559 separate investigations), was able to establish the following. The pulse, as a rule, was slowed—to a rate of 39-43 beats per minute in some patients. In 75.9 per cent of the patients, the pulse rate did not exceed 60 beats per minute. Respirations were also slowed, sometimes to a rate of 9-11 per minute. Acrocyanosis was noted in 91 per cent of the patients, hyperhydrosis in more than 73 per cent. The pupils, as a rule, were constricted. Dilatation of them was observed in only 1.5 per cent of the cases, and then only in patients who expressed emotions of suffering. The parasympathetic vegetative reflexes (Aschner, orbidal, "Ersatz"; Czermak, solar, parasympathetic palato-cardiac, clinostatic) were either positive (i.e., reactions were of the parasympathetic type), or absent, but none was reversed. On the contrary, the sympathetic reflexes (the sympathetic palato-cardiac, Rubino) in the cases in which they were not absent, were reversed (i.e., were of the parasympathetic type) and sometimes did not elicit sympathetic movement. As was shown by L. Z. Pavlotskaya,[14] bradycardia in patients with schizo-

phrenia is associated with low blood pressure. T. A. Nevzorova, studying 49 schizophrenic patients, preferentially of the catatonic type, discovered an increase in secretion and motility in them, usually combined with salivation, bradycardia, low blood pressure, acrocyanosis and diaphoresis, which also points to an enhancement of parasympathetic tonus.

Generalizing from the findings gathered by our clinic, one can draw the following conclusions:

(1) Predominance of tonus of the parasympathetic division of the vegetative nervous system is characteristic of schizophrenia.

(2) This peculiarity is the more sharply expressed in catatonia, but it can also be seen in other forms (syndromes) of schizophrenia.

(3) Such a predominance of the parasympathetic division disappears or is significantly suppressed when the patient recovers or a remission ensues (spontaneous or therapeutic).

(4) In patients in whom, under the influence of active therapy there is no remission, there is also no improvement in the state of the vegetative nervous system. Consequently, the disappearance of the parasympathicotonia is connected with the onset of remission and is not based on the use of active therapy or on its consequences.*

Let us turn now to the question of certain peculiarities of metabolism in schizophrenia. In the first place, attention is attracted to the metabolism of carbohydrates, since here there is a particularly clear and direct connection between metabolism and the influences regulating the vegetative nervous system. First of all, it is necessary to point to a series of works conducted over a number of years by L. A. Khaymovich[16] in the biochemical laboratory of the Ukrainian Psychoneurological Institute, in close contact with our clinic. The author established that in patients with schizophrenia one can observe a blood sugar content which is low, as is the content of triazophosphoric, phosphopyruvic and lactic acids. Does this low level of the separate segments of carbohydrate metabolism depend on a very intensive utilization of carbohy-

*As is apparent from what has been said, our findings in many respects agree with those obtained by Gellhorn,[15] but in our treatment of them we differ with this author. Without going into a more detailed critical evaluation of his views, let us note only the basic ones: In our opinion, the change of tonus and reactivity of the vegetative nervous system is only one of the manifestations of schizophrenia and not the cause of it, as Gellhorn suggests.

drates, or, on the contrary, on a slow course of the processes of metabolism, in consequence of which the products of metabolism being studied are formed in insufficient amounts? The low glycolytic activity (Korotkevich) and the slow disappearance of lactate, after loading with it, argue in favor of the second conjecture.

L. A. Khaymovich suggests a parallel between the peculiarities of carbohydrate metabolism in patients with schizophrenia and in animals in a state of hibernation. In the latter there is a slowing of respiration, oxidative processes are diminished, the anabolic phase of metabolism acquires predominance over the catabolic, carbohydrate metabolism declines, and the activity of a number of enzymes falls off. Let us note in passing that in animals in hibernation the higher divisions of the nervous system are inhibited, and in the area of the vegetative nervous system, the parasympathetic division gains predominance over the sympathetic.

It is known that the administration of adrenalin to certain hibernating animals (hedgehogs and others) leads to an increase in metabolism and an arousal from hibernation; while the injection of insulin during the period of wakefulness produces sleep for several days. L. A. Khaymovich investigated the way in which the influence of these substances is reflected in the glucose curves —upon loading—in patients with schizophrenia. Generally in schizophrenics, these curves have a pathological character with various degrees of deviation from what is observed in health. It developed that, with the injection of adrenalin, the carbohydrate metabolism of patients briefly approximates the normal; the glucose content and lactic acid content rise; the glucose curves become closer to normal. Insulin, on the contrary, enhances the pathological peculiarity, with the glucose curves becoming similar to those characteristic of severely ill schizophrenics.

Another important trait distinguishing schizophrenics from healthy persons lies in the fact that the schizophrenic's nervous system does not react as does that of the normal to changes in the composition of the blood, especially to changes relating to the metabolism of carbohydrates. This peculiarity was particularly apparent in the findings of Z. Ya. Kovaleva. She studied schizophrenics with the aid of the so-called "double load." The subject was twice given 50 Gm. of glucose with a 30-minute interval between administrations, and determinations were made of the blood sugar content. In healthy persons the first administration is accom-

panied by an increase of this indicator, but the second does not elicit such an effect. Apparently the first load puts into operation an adaptive reaction which assures the conversion of glucose to glycogen and its deposition in the tissues, chiefly in the liver. On the strength of such a reaction the new load is taken up so quickly that it does not elicit even for the course of a half-hour a noticeable elevation of the blood sugar content. As regards the schizophrenic, in 154 of 158 subjects, the second administration of sugar caused a new rise of the glucose content in the blood. Consequently the reaction of the patients to the administration of sugar was not like that in healthy persons; the adaptiveness of the organism in handling the additional carbohydrate was inadequate.*

Witness is likewise borne to the disruption of the reactivity of the nervous system in schizophrenia, by the well-known fact that in schizophrenic patients the administration of large doses of insulin sometimes does not cause coma. Is such an elevation of resistance in respect to insulin related to certain changes in the brain caused by the schizophrenic process? Apparently it is so related. This is confirmed by observations by L. G. Ursova. In 30 patients, treated repeatedly over a number of years with insulin in our clinic, the "shock" dose of insulin grew larger in proportion to the progression of the disease. On the average it was about 84 units in the first course of treatment, in the second, 145, in the third, 151, in the fourth, 164, and in the fifth, 220 units. B. A. Tselibeyev's data argue even more decisively for a connection between the sensivity of the nervous system and the resistance to insulin. He studied the question of the possibility of removing the motor stimulation which so frequently develops in the period of hypoglycemia and which complicates greatly the conduct of insulin therapy. We started from the supposition that hypoglycemic stimulation and the separate spastic twitchings and convulsive attacks accompanying the administration of insulin therapy, have similar pathogenic mechanisms. In a number of preceding works conducted in our clinic, it was established that the development of the convulsive phenomena in insulin therapy is facilitated by water loading, alkalosis and vasoconstriction. Dehydration, acidosis and dilatation of the vessels, on the contrary, make the development of the convulsive phenomena more difficult.[17-18] In complete agreement with this,

*Comparable findings were obtained also by a group of investigators under the direction of Hoskins.[4]

B. A. Tselibeyev's observations showed that dehydration and vasodilation (with amyl nitrate, sodium nitrate, diuretin and other agents) weaken stimulation in the period of hypoglycemia, whereas, on the contrary, significant water loading and alkalosis, caused by the administration of large amounts of bicarbonate, strengthen it. Along with this, it was discovered that measures diminishing stimulation also impede the development of insulin coma and weaken it. On the contrary, the conditions strengthening stimulation also facilitate the quicker onset of coma and deepen it. Leaving aside the part of Tselibeyev's work which relates to the practical task of countering the hypoglycemic stimulation, we are able to state that in every case, the insulin reaction caused by the administration of large doses, and expressed in the development of coma, can be changed, depending on the high or low cortical excitability, which appears to a certain extent as indicating inclination to epileptiform seizures.*

Hence, we encounter three basic groups of phenomena in schizophrenia: In the area of higher nervous activity there is inhibition embracing the cerebral cortex and extending to the subcortical formations; in the vegetative division, there is predominance of the parasympathetic tonus; in the area of metabolism, unique changes and reduction of carbohydrate metabolism. Is such a combination purely accidental?

For an answer to this question, let us examine first the interrelations between inhibition of the nervous system and parasympathicotonia. We must first turn our attention to the similarity of biological significance of the two series of phenomena. I. P. Pavlov indicated that inhibition is a state in which the activity of the nerve cells is diminished, and the reducing processes in them are strengthened. He wrote: "... very many of our experimental data lead to the concept that the inhibitory process, probably, stands in connection with assimilation, just as the stimulatory process, be it understood, is connected with dissimilation."[19, p. 228] In *A Textbook of Physiology* (under the editorship of K. M. Bykov) it is

*In addition to this theoretical conclusion, B. A. Tselibeyev's findings are of interest in other respects. First, the possibility of facilitating the onset of coma, by the method just indicated reveals ways of producing it with minimal amounts of insulin and of rectifying "insulin resistance" in schizophrenics; second, the establishment of the known independence of coma (determined by the changes of sensitivity of the nervous system) from the blood sugar content allows an understanding of the genesis of certain post-insulin comatose states which cannot be reversed with repeated injections of glucose.

said: "Inhibition of the cortex is a special active state of it. I. P. Pavlov established that this condition aids in the diminution of the degradation and reduction of substances utilized in the activity of the brain."[20, p. 733] Hence, with inhibition, there is a restoration of strength available to the nerve cells with stimulation of them.

The predominance of parasympathetic tonus plays a similar role, primarily in respect to the internal organs. As Cannon showed, an increase of sympathetic tonus leads our entire "internal economy" into a state which assures the most satisfactory condition for external activity. In this process, metabolism is enhanced, the consumption of oxygen is increased, the content of glucose in the blood is elevated, the blood supply to the brain is improved, as well as that to the muscles and other strongly active organs, while the gastro-intestinal tract, on the contrary, is inhibited. In contrast to this, predominance of parasympathetic tonus creates in the organism a condition which is less favorable for the performance of external activity, but which facilitates rest and restoration to the greatest extent. With sympathicotonia, there is a prevalence of catabolic processes, while with parasympathicotonia, anabolic processes prevail.

Such a conception, based primarily on the works of Cannon and W. R. Hess, must not be confused with the views of Eppinger and L. Hess. The latter interpreted the interrelations of the two divisions of the vegetative nervous system as a narrow antagonism, with opposed actions in each separate organ. This view was not confirmed and is now outdated. In the contemporary view, one may speak, not of antagonism, but rather of synergism of the sympathetic and parasympathetic divisions, which supplement each other in bringing about various functions of the organism: One is chiefly active in external activity, and the other in restorative processes. To dispute this synergism by obscuring it with the errors advanced by Eppinger and L. Hess would be like throwing the dirty bath water on a newly bathed baby.

Hence it must be considered that both inhibition in the brain and parasympathicotonia in the vegetative nervous system fulfill, in one sense, similar biological functions: the assuring of rest and restoration of strength (it is understood that both inhibition and parasympathetic regulation also accomplish a number of other functions, which we cannot discuss here).

In connection with what has been said, one cannot ignore the fact that sleep, a state of the most complete and perfect rest and restoration of strength, is characterized by an excess of inhibition in the cortex, on the one hand, and a predominance of parasympathetic tonus on the other.

Concerning the connections of sympathicotonia and stimulation, a number of matters will bear examination. E. A. Asratyan showed that transection or extirpation of the cervical division of the sympathetic nerves entails a weakening of the stimulatory processes in the cerebral cortex. It is not accidental, of course, that a number of pharmacologic substances (caffeine, cocaine, ephedrine, phenamine, and others), in addition to strengthening the process of stimulation and causing sleeplessness, are, along with this, also sympathetic agents. In schizophrenia, there is also a comparable type of connection between the strengthening of stimulation or of inhibition and the state of the vegetative nervous system. This is confirmed by numerous observations made in our clinic, which show that in the effects on schizophrenic patients, especially in a state of catatonia, of various substances (atropine, scopolamine, pilocarpine, cocaine, caffeine, ephedrine, phenamine, pervitin, etc.) weakening of the schizophrenic symptomatology is combined with a reduction in parasympathicotonia, while strengthening of the manifestations of schizophrenia, on the contrary, is combined with dislocations in the sense of a strengthening of parasympathicotonia.[12, 21-23]

On the basis of these findings, we long ago expressed the conjecture that the phenomenon of inhibition in the cerebral cortex and the predominance of parasympathetic tonus in schizophrenia should not be regarded as isolated and independent of one another; they are interconnected and are part of the general pathologic syndrome.[1-3]

Let us turn now to certain peculiarities of metabolism in schizophrenia.* In patients with schizophrenia, we observe a lowering of basic metabolism, a sluggish carbohydrate metabolism, and a weak-

*We shall speak here almost exclusively of carbohydrate metabolism. The disturbances of the metabolism of fats are apparently of a secondary character. The disturbance of protein metabolism, as it may be considered on the basis of the work of Buskaino, Hessing, V. P. Protopopov and others, has a closer relationship to pathogenesis than to the etiology of schizophrenia. The majority of authors incline to the view that it is precisely the disruption of protein metabolism which leads to the formation of poisonous substances which are the fundamental pathogenic factors.

ened reactivity of the nervous system to the changes of the composition of the blood.*

Can these traits be connected with inhibition and parasympathicotonia? Starting with what has already been said here, one may suggest such a hypothesis.

Adapting to the changes in the surrounding conditions, the animal organism elaborates several variations of life conditions or states. The alternation of light and darkness leads to the development of the alternations of wakefulness and sleep, that is, to interchanging periods of activity and rest. Unfavorable conditions in the cold winter months or in the dry summer months prompt the formation of such adaptive reactions as winter hibernation (hamster, marmot, suslik [ground squirrel], hedgehog, bat, Russian bear) or summer estivation ("tanrek," certain species of susliks). In both cases the animal reacts to the change of temperature of the surrounding environment and to insufficient food by a complicated complex of interconnected changes in the general state of his organism. With all the differences between them (wakefulness, sleep, hibernation) and other reactions related to them, one cannot fail to observe that they form two basic types, which can be designated as "active" and "passive." The first is characterized by a state of external activity, of movement, of a high level of reactivity to the changes in the surrounding environment. In the brain, a state of stimulation is easily aroused, sympathetic tonus predominates over parasympathetic; metabolism is elevated, and catabolic processes predominate over anabolic; and a high oxygen consumption occurs. In the second basic type, there is immobility, lowered reactivity to external stimuli. In the animal's nervous system a state of inhibition prevails; in the vegetative, the parasympathetic division holds sway; oxygen consumption is reduced; the general control of metabolism is changed so that catabolic processes are minimized and anabolic processes are strength-

*Findings obtained by us require a decisive refutation of the hypothesis as to the nature of schizophrenia advanced by Hoskins.[4] In his opinion, schizophrenia results from an incapacity for adaptation, especially with respect to the maintenance of homeostasis. This incapacity is caused by a defect of growth, of insufficient maturation. However, clinical observations definitely argue that the weak reactions to changes of the external and internal environments (defects of adaptation, according to Hoskins) are not a constant peculiarity of the patient's nervous system. This reaction is strengthened or weakened in relation to the course of the disease and acquires a normal character upon recuperation.

ened; in favorable conditions of feeding, a tendency is noticed toward accumulation of fats; in unfavorable conditions, the animal shows ability to get along with a minimum of feeding.

These two variations, naturally, find their reflection also in pathology. The conditions provocative of illness may elicit, in the organism, a reaction bearing the character either of an "active" or of a "passive" complex. Be it understood, neither the one nor the other represents an exact duplication of the prototype in health, but reproduces it with various gaps and distortions, sometimes only in the form of a hint, sometimes, on the contrary, with extreme strength and unusual fidelity to the original picture.

Starting from such a hypothesis, one can conjecture that the maniacal phase of cyclothymia is a pathologically reinforced "active" dislocation in the organism. Hence, the extreme activity and the enhanced mobility of cyclothymic patients; each idea is carried into action without inhibition; in the cerebral cortex, stimulation predominates over inhibition; a lively responsiveness is seen to the external environment and its stimuli; sympathicotonia prevails (as was shown by V. P. Protopopov); and there is a predominance of catabolic processes over anabolic, in consequence of which the patient grows thin. The picture of acute phenamine* intoxication, and that of poisoning with related substances are of this type, although with certain changes.

In contrast, the different syndromes observed in schizophrenia, especially the catatonic form, can be regarded as a reaction of the "passive" type, evoked by pathological conditions. The characteristic combinations in this disease of excess inhibition of the cerebral cortex and subcortex, the parasympathicotonia in the vegetative system, and the peculiarities of metabolism that have been described become understandable in this frame of reference. In particular, the strengthening of the anabolic processes in schizophrenia was observed long ago, and the tendency toward the storage of fats is regarded as an unfavorable sign, presumptive evidence of a chronic course. This characteristic was employed in the pre-Kraepelin period in the prognosis of those forms of disorder which were later called manic-depressive psychosis and schizophrenia.

*Amphetamine (d-1-phenyl-2-aminopropane [phosphate or sulfate]).

In the light of the foregoing, one may find the explanation of the at-first-glance incomprehensible tolerance of schizophrenic patients for large doses of insulin. One may consider not only "hyporeactivity" in response to the injection of this substance into the organism, but also the fact that the brain, having reached a state of "*vita minima,*" may get along with minimal amounts of sugar. The same thing, apparently, may be said of oxygen. To what degree the consumption of this falls off in connection with the change in the general state, may be shown by an example. Bats and hedgehogs, pushed under water in the waking state, suffocated within two or three minutes, while two bats in a state of winter hibernation, survived under water without harm for 11 and 16 minutes, and a hibernating hedgehog revived after being under water between 22 and 29 minutes.[24] As is known, the uptake of oxygen is also reduced during ordinary, physiologic sleep, although, of course, not nearly to such a degree as this. In contrast to the "anoxic" theory of schizophrenia, it is relevant to express the following hypothesis: The nerve cells of the schizophrenic patient do not reach a state of inhibition because they do not receive sufficient amounts of oxygen; but, on the contrary, they use little oxygen precisely because they are inhibited—this is exactly what is observed in physiologic sleep and winter hibernation, that is in conditions that could in no wise be described as of "anoxic" origin.

These are the basic positions which we wish to set forth in the capacity of a working hypothesis. Guided by it, we conducted studies of schizophrenics for a number of years. We take fully into account the weak aspects of the proposed concept; but, meanwhile, we cannot forget that a hypothesis which permits fitting the accumulated data into a unified system, regarding them from a general point of view, and establishing a guiding point for further progress, seems a necessary instrument in our investigations while "...with a complete disregard of the hypothesis, i.e., a guiding concept, science would turn into a pile of bare facts" (K. Timiryasev).[25]

Care of The National Institutes of Health
Bethesda, Md.

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THE CHILDHOOD SCHIZOPHRENIC IN ADOLESCENCE

BY EDWARD G. COLBERT, M.D., AND RONALD R. KOEGLER, M.D.

Many psychiatrists avoid making diagnoses when confronted with emotionally disturbed children, feeling that "labeling" a child is unnecessary and perhaps even harmful in view of his ability to recover quickly from emotional disorders. Consider this quotation from a prominent child psychiatrist: "... we are beginning to consider it clinically (that is, prognostically) fruitless, and even unnecessary, to draw any sharp dividing line between a condition one could call psychoneurotic and another that one could call psychosis, autism, atypical development or schizophrenia."[1]

There has been some doubt expressed concerning this time-honored concept of the malleability of the young psyche,[2] but it is not the authors' intention to enter into a general discussion of this theoretical problem. They do feel, however, that there is considerable evidence that one particular type of child, the schizophrenic, shows very little resilience. Follow-up studies have failed to show that treatment (including psychotherapy) alters the natural course of the illness.[3, 4]

One investigator has neatly solved the whole problem by denying, on theoretical grounds, the possibility of schizophrenia existing before adolescence.[5] Another has categorically stated, "Schizophrenia is not a disease of childhood. Its onset is in adolescence and pre-adolescence."[6] It is the writers' belief that such persons are emotionally blind to facts in this matter, perhaps because they over-identify with the child. The results of this attitude are clearly demonstrable in the childhood schizophrenic in adolescence, who has usually been seen in several clinics without having received adequate diagnosis or therapy.

This paper is directed toward those who do feel that there is an entity, or group of entities which can appropriately be called childhood schizophrenia, who are cognizant of its prognostic implications, and who, like the authors, have had difficulty in making this diagnosis during adolescence.

It has been pointed out by Bender[3] that there may be considerable superficial clinical change in the childhood schizophrenic when he reaches adolescence, so that his disorder bears a marked

resemblance to other entities, including neurosis, psychopathy, and mental retardation. This chameleon-like quality of the childhood schizophrenic is certainly the source of a great deal of confusion when trying to differentiate him from these nonschizophrenic entities. However, even when the adolescent is obviously psychotic, the diagnostic problem is not at an end; for it is at this age that cases of the adult type of schizophrenia, called originally *dementia praecox*, are first seen.

It was decided, therefore, to study adolescents whose schizophrenia had appeared in early childhood (adolescent childhood schizophrenics), contrasting them to other emotionally disturbed adolescents in the community. Forty adolescents, aged 12 to 17, who had been childhood schizophrenics, diagnosed by Bender's criteria,[3, 7] and a control group, consisting of 20 adolescents with "behavior problems" and 20 adolescents who became schizophrenic in adolescence, were evaluated by means of longitudinal histories, clinical evaluations, Goodenough Drawings, Bender Gestalts and tests for the "whirling phenomenon."[8] The study was done at UCLA Medical Center, Los Angeles; Camarillo (Calif.) State Hospital Children's Unit and Vista del Mar (Calif.) Child Care Center. Readers are referred to a previous paper for specific diagnostic standards.[9]

Longitudinal Histories

Retrospective studies of charts and direct interviews demonstrated that the majority of adolescent childhood schizophrenics had very early demonstrated severe disturbances in eating, sleeping and toilet training. These were significantly greater than the amount of disturbances in these areas seen in the control groups.

Immaturity on all levels, if not noticed by the parents of the childhood schizophrenics, was commented upon by kindergarten teachers, and statements of "looks and acts younger than stated age" appeared with monotonous frequency. Seven of the parents of childhood schizophrenics had expressed concern over their children's frequent turning in circles[9] (one had actually collected motion pictures of the curiosity, an activity which had lasted for 10 years), while one presented this habit as the current major complaint, stating, "I have tried and tried to break him of it with no luck." Persistent toe-walking,[10] still present in one child, was a phenomenon noted by past observers in six other cases. In the controls, persistent toe-walking and spontaneous circle-turning

did not appear, either as observations or as complaints in any of the children's records.

Clinical Data

The average adolescent childhood schizophrenic in the 12-to-14-year-old group still appeared markedly younger, both physically and psychically, than his peers. Speech was often so high-pitched and immature that the authors' co-workers, knowing none of the data, could make the diagnosis with little difficulty. Weight was usually greatly under or over the statistical norm. The vast majority displayed poverty of thought and had marked sexual confusion. Those under 15 were obsessed with space, time and motion (Figure 1), filling their every moment by drawing rockets, trains, super-cars and watches. These preoccupations could in no way be confused with the frequent adolescent interests in "hot rods and jets," which form only part of otherwise active lives. Only one childhood schizophrenic had in the past or the present developed a systematized delusional state. These findings were not true of the controls.

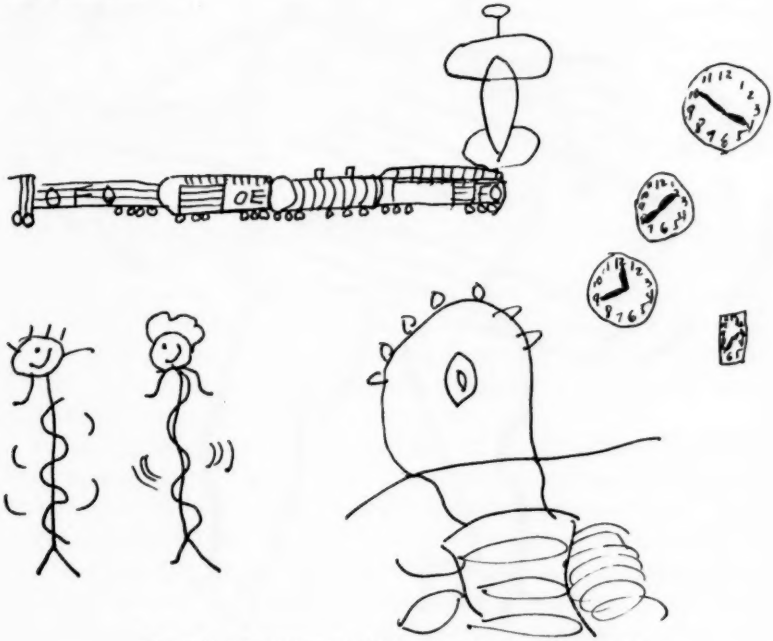

Figure 1. By adolescent childhood schizophrenic, aged 12

Goodenough Drawings

Human figure drawing by the childhood schizophrenics displayed marked distortions in body image, frequent use of "stick drawings" (Figures 1 and 2); and they most often emphasized their concern about body periphery, nose, hands, feet, and so on. Those under age 15 showed their continued interest in "whirling" and space-motion concepts. (Figures 1 and 2.)

Figure 2. By adolescent childhood schizophrenic, aged 12

Marked concern over body periphery was evident in seven of those whose schizophrenia appeared in adolescence, negating this finding as a differential sign. It was not found at all in the nonschizophrenic group.

Bender Gestalt

A somewhat typical gestalt (Figure 3) for the childhood schizophrenic demonstrates "vortical activity" as the predominant pattern. By this, is meant the pulling around of figures so that the whole pattern appears in whirling motion. (Contrast this with the visual-motor patterns of a neurotic adolescent, as seen in Figure 4.) This phenomenon, which appeared to be the outstanding test differential in the study, has been previously reported,[11, 12] but in the present authors' experience has frequently been denied or neglected. Since it was not found in either control group, this phenomenon is important as a differential test.

"Whirling Phenomenon"[8]

In addition to three childhood schizophrenics who continued to whirl spontaneously in play, 12 others could be whirled freely about their longitudinal axes. Testing was negative in 10 and equivocal in nine of these 40 children. Six could not be tested. Ten of the nonschizophrenic controls, four of whom had reading disabilities, could be whirled freely, demonstrating that this test is of doubtful diagnostic value.

Psychotherapy

One obviously cannot evaluate the effect of individual psychotherapy upon childhood schizophrenia with this population, since it can be rightfully stated that the authors may have seen only cases which were therapeutic failures. It can be said, however, that review of the cases shows, in general, little difference between the treated (a minimum of 18 months out-patient or in-patient care) and untreated groups as they now appear.

In the 18-month observation period, 10 of the adolescent childhood schizophrenics appeared to be benefiting from a long-term supportive relationship with accepting adults of the same sex. Residential placement, with avoidance of chaos and re-enforcement of psychopathology, was best accomplished when the childhood schizophrenics were not grouped in school or living situations with "character disorder" adolescents. Visual-motor problems, reading disabilities and speech defects, problems which are often neglected,

can be worked with and therapeutic gains accomplished with these adolescents.

Those whose schizophrenia appeared in adolescence also had an extremely poor response to therapy, as might be imagined. The

Figure 3. "Vortical activity" in the Bender Gestalt. By adolescent childhood schizophrenic, aged 12

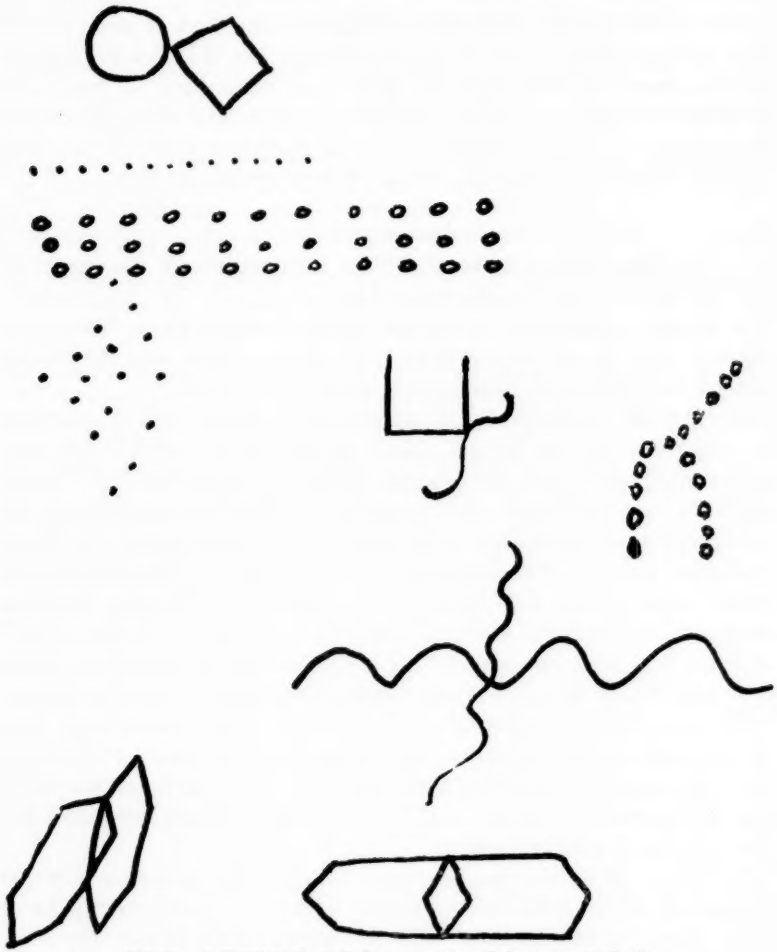

Figure 4. Bender Gestalt by neurotic adolescent, aged 12

small number of cases in the series and the ever-present difficulty of measuring improvement made it impossible to say definitely if there were differences between them and the childhood schizophrenia group. However, because of their previous relatively normal level of development, there is always a possibility with this group with onsets in adolescence that improvement will result in fairly normal function. This possibility is remote in the treatment of the childhood schizophrenics.

The picture in the behavior-problem adolescents is so different that a comparison of the results of therapy is not indicated. Superficially, most of them improve and make some kind of non-institutional adjustment. The possibility exists that they are more dangerous to society than the schizophrenics because of their surface normality and may be a greater social problem.

Summary

1. The importance of establishing a diagnosis in the emotionally disturbed child has been emphasized.

2. Forty adolescent childhood schizophrenics have been contrasted with 20 adolescent behavior problem cases and 20 adolescents whose schizophrenia appeared in adolescence.

3. (a.) The childhood schizophrenics revealed: (i) a tendency to early and severe physiological disturbances and showed general immaturity; (ii) a frequent history of spontaneous "whirling" and toe-walking; (iii) poverty of thought, marked sexual confusion and obsession with space, time and motion in those under 15; (iv) marked distortion of body image, with concern over bodily extremities and spacial orientation; (v) Bender Gestalts emphasizing "vortical activity"; and (vi) positive "whirling tests" in many but with the presence of positive tests in controls making it apparent that this test is not diagnostic of itself. (b.) The adolescent schizophrenics showed none of these symptoms except for: (i) marked sexual confusion; (ii) confusion about body periphery; and (iii) positive "whirling tests" in some. (c.) The behavior-problem adolescents had none of the gross abnormalities described for the childhood schizophrenics.

4. There appeared to be some therapeutic gains in several adolescent childhood schizophrenics who were experiencing long-term "relationship therapy" with accepting adults of the same sex.

5. Remedial reading, speech therapy, visual-motor training must be of primary concern in all therapeutic programs.

Neuropsychiatric Institute
UCLA Medical Center
Los Angeles 24, Calif.

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GROUP THERAPY WITH PARENTS OF ADOLESCENT DRUG ADDICTS

BY ROBERT HIRSCH, M.D.

Review of Literature

Although much has been written on the parents of disturbed children, there has been relatively little in the group therapy literature on parents of adolescent drug addicts. Healy and Bronner[1] in their study felt that "antisocial children identified themselves with gross ethical distortions of parents"; Johnson[2] saw the mother as unconsciously encouraging the amoral or antisocial behavior of the child. The same author felt that the needs of the parent are gratified by the behavior of the child who blackmails the parent who is guilt-ridden about discipline.

In a series of papers,[3-5] Gerard and Kornetsky showed that the relations between the parents of adolescent addicts are poor and grossly disturbed. They saw the addict as unable to break the ambivalent tie with his mother without guilt. Their studies also revealed the strong familial need for high attainment and the inculcating of high levels of aspiration and expectation into the children. In an important paper on moral masochism, Bromberg[6] viewed the mothers of "moral masochists" as people with above average aggressive impulses, narcissistic, hostile and inconsistent. Bromberg felt that these mothers have a great need to control and that they unconsciously identify the child with one of their own parents or siblings. Berliner's recent paper on masochism[7] came very close to the core conflict of the adolescent narcotic user, as he stated that the very young child misidentifies criticism and punishment as a form of pleasure and thus goes through life reliving (under the repetition compulsion) the original distortion. Berliner went on to state that the hated child denies the parental ill-treatment and accepts hate as if it were love; "suffering is thus libidinized and introjected, and the trauma becomes ego-syntonic."

Introduction*

On April 15, 1958, a project was undertaken at the Riverside Hospital After-Care Clinic which involved the group therapy of

*Before giving a brief description of the patients in the project to be discussed, the writer would like to express his appreciation to Miss Hazle Harte, R.N., who is the co-ordinator of the clinic, and to Dr. Raphael Gamso, director of Riverside Hospital. Without their co-operation administratively, this project would never have become a reality.

parents of adolescent drug addicts. Riverside Hospital had been opened on July 1, 1952 by the New York City Department of Hospitals for the care and rehabilitation of adolescent drug addicts. The bed capacity is 140; and, since its inception, this institution has had over 1,600 first admissions. The idea of treating mothers rested on firm clinical grounds, since it is basic in psychiatry that the unconscious conflicts of parents have a profound effect on the behavior and feelings of their children, who, upon leaving the hospital, must return to their original environments. It was felt that treating the young addict, either in individual or group therapy, was certainly not sufficient to effect a permanent change or, in many cases, even an alteration in behavior. When this experiment was undertaken, the main purpose was to learn and understand what some of these parental conflicts were; discussions with the addict gave one picture of the parent; the author was interested in hearing from the mother or father.

It became clear almost immediately that the parents were bringing their own neurotic difficulties into the group. Their sense of guilt and their inability to accept the roles of patients made it very difficult to put the group on a therapeutic basis. Almost always, they were looking for judgment and for many weeks the question of acceptance of treatment was the paramount problem in the sessions. Over and over again, the group members denied that *they* needed help, their concern was their addict sons or daughters and how to manage them. Their anger at consistent confrontation caused some of the initial group to flee therapy; actually the inability to accept their hostile aggression was an important source of acting-out in terms of missing sessions, lateness and silences. Early in therapy the group nucleus was formed —four mothers and one father. They looked upon the therapy as a "class" or a "lecture" program, and their acceptance of the patient-role became at once an important area of investigation.

Time and space prevent discussion of the complete case histories of the five group members who constituted a rather permanent nucleus; one of the members died from a fulminating carcinoma, so that three women and one man were left. It was felt that the mobilization of unconscious guilt was not an essential preliminary maneuver, these patients were guilt-ridden from the beginning; but when it became overwhelming, projection of responsibility on others was a prominent mechanism of defense. In

general, the group requested advice; for members to focus on themselves became a very difficult task. The selection of the group admittedly was not on any specific basis, circumstances in the clinic made it necessary to select parents who were available and interested; the one variable which is probably the most important and significant dynamically for any group was the various character-structures, and in this group this was evident. Each patient was seen for an hour before admission into the group, some idea of the clinical diagnoses and dynamics was arrived at; and, as a preliminary maneuver, the patient was in a sense "oriented" to what group therapy was and why the project was undertaken as an adjunct to the treatment and rehabilitation of the adolescent drug addict.

The goals, as has been said, were admittedly not definitive. As one essential, the writer wanted to learn if the group helped the patient see that he too had conflicts; this was to be considered a major step. Essentially then, it was hoped that in this project a global or bird's-eye view of this problem as regards the parent-child interaction could be obtained. It was hoped that others at Riverside Hospital and elsewhere would also be stimulated to work with the mothers and perhaps the fathers of these young narcotic drug users and thus fill in some of the gaps in our knowledge of this ever-increasing problem.

The Patients

Case 1

A is a 47-year-old, Roman Catholic shipyard worker of Italian derivation. He is short of stature. In the first individual session, he told of how well his two sons played baseball. His son's addiction was a blow to his own self-esteem, which was already low because of his own inability to become a "major-leaguer." He tried hard to impress the writer with his abilities as a member of many youth clubs, where he functioned as a "big brother." His wife's psychotic depression was blamed on his addict son, but in actuality he related to her as an unfeeling man who substituted activity for feeling. He saw his son as "knifing me in the back." He verbalized much anger as he talked about "dope peddlers" whom he wanted to kill. Essentially, A wanted to be "a pal" of his son; he competed with the boy who out-distanced him athletically and angered him on a deeper level.

Diagnostically, A was seen as having a passive-aggressive character-disorder with compulsive features; his major defensive structure con-

sisted of denial, intellectualization and projection, along with conscious fabrication. He is a man who feels extremely inferior, and he does much in an ineffective manner in an effort to compensate. His anger toward his son became more and more obvious; and, on not so deep a level, his unconscious hostility (and ineffectiveness) was communicated to the son.

Actually A did very little in a realistic way to help the boy; there were the "pats on the back" and the usual "be a man" clichés; he was superficial, and he generalized often. His hostility to women became clear as he referred to his wife as a "baseball widow" and as a "girl that started my son off on drugs." This was an angry little man protecting himself in the best way he could from the guilt he felt.

Case 2

Mrs. B is a 40-year-old married woman who has a husband and three children (a daughter aged 23 who is making a good adjustment, a son aged 20 who is the addict, and a five-year-old daughter). She entered with a fair conception of what group therapy was concerned with. She revealed that she was "tensed up" and impatient with her younger daughter. Almost immediately it became clear that her marriage (she was married at 16 because her "father remarried") was a conflictual area; she felt her 50-year-old husband invested very little in the family. Mrs. B, it seemed, was partial to her older daughter who always was a good student; the competition between her son and older daughter was fostered by Mrs. B; and, in therapy, Mrs. B saw this with some affect.

In an indirect way, Mrs. B, like many other parents, "bought" drugs for her son. Such parents supply their children with money, paying for their pawned clothes, etc. (One mother who left the group said, about her nonpsychotic, manipulative son, "I had to give him money when he threatened to kill somebody with a screwdriver.") Mrs. B's sexual adjustment was poor. There had been no orgasm for two years and her complaint was that she couldn't get close to her husband. She had five brothers who "depended" on her and this was a clue to her relationship with her son. Diagnostically she was seen as having a hysterical character disorder with severe Oedipal problems and "acting-out" concerning her son. In the group she was rather verbal, and at times she become the "assistant doctor." Her prominent mechanisms included intellectualization and repression, but she became "motivated" for therapy when she, at long last, saw her own role in the production of her son's psychopathology.

Case 3

Mrs. C is a 47-year-old Jewish saleswoman who has a chronically ill husband (cardiac) and two sons, the younger of whom is the addict. The other son is apparently making an adequate adjustment. Mrs. C has

been married 26 years to a poor provider, a gambler, and, according to Mrs. C, a pathological liar who impulsively beat his children frequently. She gave the impression of being an angry, repressed woman who is much afraid of her husband and her own aggressive impulses, which apparently were projected onto her son in terms of rejection and inconsistent control. She related warmly and somewhat seductively; she verbalized her guilt and told how she and her own mother had never been close because of the dominating influence of the latter. Her father was reported as an "alcoholic," but, when questioned in detail, she said that he really wasn't an alcoholic—that she had seen him drink once or twice. She was diagnosed as having a compulsive character disorder with hysterical and masochistic features.

Her sexual adjustment was poor in terms of orgastic ability. Mrs. C was a hostile, angry woman who had to submit passively. Her guilt was a motivating force in bringing her to therapy, but she, too became aware of her own role in her son's addiction. During the course of therapy, Mrs. C had her son sent to jail; and, ironically, this was the first protective action performed since her son became addicted; both son and mother felt relieved when this occurred. Mrs. C's defenses included projection, denial, and repression, and she related in the group passively and masochistically.

Case 4

Mrs. D is a 50-year-old married, Roman Catholic housewife, whose only son (legally adopted) is a drug addict of long standing. He is the illegitimate son of Mrs. D's brother (who committed suicide). The mother had given up the child. The boy was told of his adoption when he was seven years old, but he still denies ever having been adopted. Mrs. D has been an ulcer patient on medication for the past four years. Her mother is 72, and she too has "stomach trouble"; her father committed suicide when the girl was 14 years old. A sister, aged 53, is childless; and a single 46-year-old brother has been in a Veterans Administration hospital for 18 years because of a "nervous breakdown.""

Mrs. D related to the group in a passive, depressed manner; her denial was excessive but she wanted to enter the group. She appeared helpless, and she constantly saw her son as someone with a "weak mind." Her hostility to the boy became obvious, but she recognized none of it. Her husband is 51 years old and he was seen as a passive man with very little investment in the boy, who was sent to California (by the mother) to live with Mrs. D's sister. She was considered to have a masochistic character disorder with a very low feeling about herself which was unbearable for her to face. Her defensive operation consisted of projection, denial and repression; in the group, she sought advice, and was rigid and unfeeling for the boy who was always a reminder to her that she was a failure as a woman.

These histories form a brief description of the four parents who were permanent members of the group. There were others who participated for two, three or four sessions. What follows are the author's observations, which stem from his work with the parents (in and out of therapy) of adolescent drug users. The group therapy lasted for 25 sessions; it was discontinued because of the writer's inability to stimulate a therapist to continue it. The group wanted it to continue, and it was felt that this desire was genuine.

Observations on Parents of Adolescent Drug Addicts

As the group sessions progressed, it became quite clear that disturbed people, who had much to do with their children's choice of symptom—namely the use of narcotics in their attempts to cope with their internal and external environment—were being dealt with. To a large extent, the parents were limited in the language of feelings and also in the ability to be introspective; no doubt cultural factors played a great part in how they related; but in addition to this, the orientation was also indicative of defensiveness and pathology. Almost immediately, the group regressed to a "dependency phase" which manifested itself in repeated attempts to get the therapist to answer questions or to advise members about their problems. A phase gradually emerged where they blamed themselves for their children's problems; and this approach gave way to a "my son is weak-minded" attitude.

In all the parents seen, in or out of a therapeutic setting, the one consistent pattern soon established was an unhappy marriage reluctantly entered into by the woman, who is extremely ambivalent toward her children. The mother presents a characteristic picture of narcissism, seductiveness and orality; she is "giving" and permissive only when the addict gratifies her own needs; so, in essence, the child is a narcissistic extension of the mother who actually "gives to herself" when she goes through the motion of giving to her child. The parents of addicts, especially the mothers, constantly allow themselves to be intimidated or "conned" by the narcotic users. Some parents see themselves as "indirect pushers" as they literally run after the addicts, paying their accumulated debts and even giving them money which the addicts always use for drugs. The hidden hostility in this orientation became very clear in the group; and again it became very clear that the mother

reacted with rejection and aggression when the addict did not gratify her narcissistic needs.

Mothers of addicts (especially boys) have a powerful need to infantilize their offspring. In doing so, a mother bolsters her own omnipotence, which the addict can never accept in safety despite the intense dependency needs of the child. Since the growth of ego and super-ego depends so much on this acceptance of dependency and trust, it becomes easy to see the sources of developmental retardation here in the addict.

A striking feature in working with mothers of addicts is the fact that the child is like the mother in many ways; many of the mothers had tyrannical parents (usually the mother) to cope with and to rebel or act-out against. Their fathers were weak, ineffectual men and they were seen through the mothers' eyes by the children. For the addict and his mother, the adult world became a hostile, unsafe place, the resultant clinging to omnipotence is a persistent characteristic of most addicts and most mothers of addicts. The identification between the two becomes tenacious and binding, and each wants from the other what each cannot give: namely, one's self in terms of warmth, affection, and trust. The mother's longstanding sado-masochistic pattern, with the guilt involved, results in inability to love and to trust in a mature manner; her constant need that *she* be loved, cherished and admired actually damages every relationship she enters into, including the ones with her children.

The mother as well as her addict son gives the history of being powerless before a rejecting mother. This, it is felt, is where the core of the masochism lies in both parent and child, who in a sense says, "If my mother hates me, then I must be worthless or bad, because every mother is supposed to love her child." Every addict has the uncanny ability to provoke this original rejection in terms of his current environment; both mother and child get people to hate them (society's attitude toward the addict is typical of this); and thus, under the repetition-compulsion, the original parent-child relationship is re-enacted over and over again. The transference and counter-transference implications of this formulation are extremely important; and this is one of the main reasons why psychotherapeutic efforts are so difficult with drug addicts in the majority of cases undertaken.

In the group, the mothers banded together for a while reassuring themselves, later blaming each other, and finally blaming society for the dilemmas that they were in. One mother (Mrs. C), after being paralyzed with fear and inconsistency for years, finally "controlled" her son from self-destruction by turning him over to the police and this resulted in a prison sentence. It amazed the group and Mrs. C to learn that her son had always wanted this control. Actually, most of the adolescent drug addicts the author has known ask literally for control, and many times the pleading is not disguised. Mrs. C consequently became guilty and depressed over her supposed "hostility"; but when the reality was pointed out, her mood lifted and soon she became "proud" of her ability to really help her son.

The one father in the group probably inhibited the mothers for a while; future studies should not include both sexes in one group. He, it is felt, rarely did any "feeling" in the group; the verbiage became abundant; his hostility in part was utilized as a defense against loving and trusting. The fathers of addicts are generally passive men who offer very little in terms of identification for their male children. Fathers of female addicts seem very concerned over their daughters' sexual activities, of which they consciously deny the existence. As with the mothers, much marital discord seems to occupy a central position with the fathers.

Conclusions

As was stated, this project was not undertaken with any definite goals in mind. That parents of drug users, however, are intimately involved with their children's psychopathology was a fairly clear observation after working with these people, who are just as disturbed as the addicts who "mainline." The infantilization of the son by the narcissistic mother, who rejects the child when her demands and needs are not met, is of paramount importance. The unworthiness experienced by drug addicts, the very masochism reflected in sticking a needle into one's vein, typifies the image that the addict sees of himself through the eyes of the mother.

From experience, it is seen that the mother plays a dominant role in the process of identification in the addict; this coincides with the concept that the child identifies with the parent who frustrates him the most. This author feels that the addict's homo-

sexual conflict and passive orientation to women is strongly related to this.

The tremendous guilt experienced by parents of adolescent drug users is seen as a motivating force in therapy; their awareness that guilt is a useless emotion put the group reported here on a therapeutic basis, which enabled them to see, at least partially, their own involvement in their children's problems.

That group therapy for parents is *the* answer to the problem of narcotics addiction is an unwarranted conclusion; there are too few clinical studies to evaluate its merit; but the undertaking certainly rests on sound clinical grounds. This paper in a sense was written to stimulate the interest of others working in this very difficult field to investigate this approach. If this further investigation becomes a reality, this project will have accomplished its purpose.

63 Station Road
Great Neck
Long Island, N. Y.

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SOME PROBLEMS AND PSEUDO-PROBLEMS IN PSYCHIATRY

BY RICHARD D. CHESSICK, M.D.

Psychiatrists and others tend to make a dichotomy between types of psychiatric practice. A sociological description of this so-called "split" between psychiatrists has been given by Hollingshead and Redlich.[1] Those with "analytic and psychological" orientation belong to psychoanalytic institutes or wish they did, wear no white coats, are 83 per cent from Jewish homes, and tend to be "inner-oriented" or "introspective." The "directive-organic" group give medical examinations, use drugs and electric shock therapy, actively advise the patient on courses of behavior, give shorter sessions and earn more money, are 75 per cent Protestant, read different journals, and belong to different organizations. This dichotomy has lead to a great deal of misunderstanding, some hard feelings, and, most seriously, has in some cases prevented patients' getting maximum benefits from clinical psychiatry.

Psychiatry as a branch of medicine deals with the understanding, alleviation, cure and prevention of problems we call "mental" or "emotional." The word "cure," especially, implies that we must bring about a *change*—the key word—in the "mind" or in the "mental" or the "emotional life" of the patient. It is generally agreed that our first duty is to heal the patient in this very way.

Just as in other branches of medicine there is a clinical feedback. Our patients react to what we do, and we in turn adjust therapy accordingly. This is true, both for the individual patient in treatment and for the carry-over of knowledge that we learn from one patient to the treatment of other patients.

In our field, however, two great barriers handicap our learning anything. The first of these might be termed the inexactness of the material. Work with human beings involves many as yet uncontrolled variables. This situation makes it most difficult to determine cause and effect by the classical method of science. However, in this day and age, with the advent of quantum physics and the development of statistical and experimental techniques for dealing with probability, this inexactness need not be a barrier that makes learning completely impossible.

The second great barrier to our learning might be termed our unawareness about the material, a barrier which, of course, over-

laps the first. In the doctor-patient situation, we can never be entirely sure that we know what we are doing because the patient and the doctor are never aware of all the processes that are going on in them or between them. It is this barrier to our learning, plus the various attempts to get around it, that has led to the destructive dichotomy previously mentioned.

Let us begin with an example illustrating the difficulties of the situation: the use of barbiturates in psychiatry. If one peruses the literature, one finds that the same drug in the hands of different investigators has been used to produce a variety of quite different things. Some of these are: a normal night's sleep, prolonged sleep or "*Dauerschlaf* therapy," suppression (of anxiety, of conflicts, etc.), "strengthening of protective inhibition," as the phrase is used in Russian psychiatry, uncovering, or "psychoexploration," or "release of repressed material," and "narcosynthesis," a technique of treatment used in the Second World War.

Space does not permit going into the details of these various techniques, but a study of the literature makes it clear that the observer's purpose, or, more generally, the frame of reference of the investigator, has an important influence on the effect of drugs on the mind, as reported by the observer. It is analogous to the uncertainty principle of Heisenberg in physics. The frame of reference of the observer determines the choice of the drug and occasions the route of administration and the concomitant activities of the observer before, during, and after the experiments. In fact, it affects the very design of the experiment itself. Obviously, then, it has a great deal to do with the results of the experiment which, unfortunately all too often in the literature, are then ascribed purely to the effects of the drug.

What are these basic frames of reference? It is important to point out that it is *false* to oppose them to each other; this is analogous to the blind men each examining one part of an elephant and then insisting that the entire elephant was describable by the part he was examining. Obviously, the frames of reference must complement and not replace each other.

The first frame of reference is that of the basic sciences—neurophysiology and biochemistry. These disciplines can never completely explain the clinical phenomena of psychiatry. This is not because we are assuming the existence of some "vital force" as the vitalists did when they opposed the mechanists in the controversy

of the nineteenth century, but rather because of the different natures of the materials under investigation in the basic science laboratory and in the clinic. For example, let us take an electric sign which says "United States Embassy." A master electrician from another planet who does not speak English may be able to explain in complete detail the circuits, lights, and electronic intricacies of this sign. However, he may be completely unable to understand at the same time why the local Cuban citizens are throwing rocks at it, and no amount of knowledge of the electronics of the sign would ever give him the explanation. It is simply that radically different kinds of phenomena, both emanating from the same source, that is, the electric sign, are under investigation, and the scientific techniques of approach cannot be interchanged.

Both of the next two basic frames of reference arise from the clinical or laboratory investigation of behavioral phenomena. The first might be called the purely mechanistic point of view. An excellent example is the Pavlovian system. In this system, it is believed that, through experience, certain responses become connected to certain stimuli. No purpose is involved in this. It involves rather a description of the development of certain "engrams" or patterns which arise almost accidentally and which are affected by various natural processes, described by such terms as "inhibition," "extinction," "induction," "radiation," and so on. Much of human behavior is explained in this way. This frame of reference is most useful in research on groups of subjects in which variables can be controlled and cancelled out by such techniques as matching and random sampling. It lends itself to statistical description, which is most helpful for future prediction. It permits a calculation of the probability of a given event, provided that exactly the same set of conditions prevail, and comes the closest to scientific descriptions in other disciplines. Because of this, psychopharmacologists and experimental psychologists tend to use this frame of reference.

The second frame of reference may be characterized as the teleological point of view. Teleological systems carry the basic assumption that there is a purpose in human behavior and that things are done in order to avoid unpleasure and experience pleasure. The phrase "in order to" is the crucial assumption of this frame of reference. In clinical psychiatric practice, where the doctor chooses to practise in such a way as to deliberately discuss

problems with the patient, this frame of reference tends to be assumed. Human beings must constantly "interact" or "transact." They are continually trying to change the environment or their situation, and their environment or situation is continually being changed by those about them. This means that one's adaptation must be constantly changed if one is to avoid unpleasure and experience pleasure. When adaptational change is blocked for any reason, the person eventually experiences severe unpleasure and is on the road that will bring him to the psychiatrist.

What has been previously said about the observer or doctor is equally true of the patient. The frame of reference of the patient has an important role in determining his reaction to the therapeutic technique, or to the drug or to the experiments in which he is involved. Some examples will make this clear. For example, Beecher[2] reports that in 15 studies involving more than 1,000 subjects, inert placebos "satisfactorily relieve" an average of 35 per cent of patients with a variety of complaints, such as post-operative pain, seasickness, angina pectoris and headaches. Furthermore, the placebos are the more effective in cases where pain or discomfort is the more severe. Patients so relieved are called by Beecher "placebo reactors," and their reaction to drugs is obviously determined by their frame of reference. Careful psychological study of this group shows that it contains no more lunatics, whiners, "crocks," or incompetents than a matched group of patients who are not placebo reactors. Placebos even had toxic side effects; for example, dry mouth, nausea, sense of heaviness, fatigue, and headache were reported.

At the Addiction Research Center in Lexington, Kentucky, extensive and excellent work has been done with lysergic acid diethylamide (LSD). Once, a patient to whom this drug had been given during an experiment suddenly began to claim that he was getting younger. In front of the experimenters, he relived his adolescence, childhood and infancy, and then declared he was in the womb as a fetus. As time went on he further asserted that he was a four-legged animal, then a crawling animal, and finally a fish. This was very dramatic and sincere. It puzzled the experimenters for quite a while, and they wondered if they had not inadvertently come across some evidence for inherited archetypal evolutionary memories. However, someone thought to look in the patient's room; and it was discovered that—in the manner of the pseudo-intellectual

ruminations common in narcotic addicts—the patient had been actively studying Darwin, Freud and Jung. On questioning the patient, it became apparent that he was quite preoccupied with these matters at the time the LSD was given. This unusual response to a drug certainly depends considerably on the frame of reference of the patient.

Perhaps even a more striking phenomenon is the difference in the responses to a clinical dose of morphine between patients who have previously been narcotic addicts, and those who are so-called normal subjects. The post-addict patient has a perfectly delightful experience from a clinical dose of morphine. The normal individual usually becomes nauseated and may vomit, suffers malaise and experiences no pleasure. Thus what the patient expects, which is determined by his frame of reference, certainly has an important effect on the results.

A clinical example might be taken from a case of involutional depression which the writer attempted to treat in the hospital. The patient was intelligent and talkative and seemed most cooperative, and the writer's initial expectation was that psychotherapy should be tried and might help. However, the patient came from a low socio-economic and educational background, a group which, on the whole, as described by Hollingshead and Redlich,[1] expects "something to be done." Therefore, in spite of the writer's efforts, the patient kept asking why he did not begin "treatment," and there was absolutely no progress. Finally, probably in desperation, the patient said that when she was sick as a child her mother used to bring her lots of orange juice; and this, she believed, had a most beneficial effect on one's health. Therefore, in the writer's own desperation, because this patient had shown no response to pharmacologic agents—which she considered were "just pills" that a previous doctor had tried—or to psychotherapy, and because medical contraindictions made it absolutely impossible for her to receive shock treatment, the writer began giving her small doses of insulin in the morning, just enough to make her sweat and feel uncomfortable. Then the writer came in, made a big production of it, sat with her, and stuffed her with orange juice, sometimes two quarts in a day. The patient made a very rapid recovery. This example again illustrates how, when the frames of reference of the psychiatrist and the pa-

tient are in opposition and are then brought together, the results are enormously affected.

The writer has stated that the basic problem of clinical psychiatry is to change the mind. Can this be done by directly influencing neuroanatomical structures by physical means? In the opinion of numerous investigators, there is a lack of good evidence for the specific and isolated actions of any substance—given in physiological amounts—separately on any of these structures, although the hope is that we shall someday be able to create specific and isolated chemical effects. At present, the giving of large, nonphysiological doses of chemicals, in the hope of affecting one specific circuit or area or system in the brain, has been compared to looking for a needle in a haystack with a steam-shovel. Histochemical studies,[3] for example, have demonstrated that there are enzymatic cerebral architectonics, which in many cases do not even follow the presently delineated anatomical structures, and which, for all we know, may be more important in brain functioning. Thus it is fair to say that the known biochemistry and neurophysiology of the brain contribute little that is of much clinical use at present in trying to change the mind by specifically influencing functional neuroanatomical units.

Perhaps this will become clearer if one asks what is meant by "mind." A most useful approach to this problem will be found in Vaihinger's "As-If" philosophy,[4] which, if stripped of its cumbersome superstructure, amounts basically to this: We form certain *fictions* which we use to explain natural phenomena. These artificial thought-constructs are "As-If" in character. They include such things as the mind, the will, psychic energy and many other artificial heuristic and explanatory constructs from all aspects of science. The "As-If" world formed in this manner is extremely important because it is "an instrument for finding our way about." The great danger of these "As-If" concepts is that they may be objectified, that is to say, given a separate substantial existence and treated as objective entities. Freud was aware of this when he repeatedly pointed out that the ego, id, and super-ego were *not* to be thought of as objective or anatomical structures in the mind or the brain. Subsequent authors have not always been so careful.

Whether we admit it philosophically or not, this "As-If" concept of the mind is what we use in psychiatry. The data or natural phenomena of psychiatry are the patient's (a) reports of his sub-

jective thoughts and feelings, and (b) observable and reported reactions to, and interactions with, the people around him. This includes his behavior, appearance, and measurable indicators, such as sweating and blood pressure, in his reaction to, and interaction with, others, including the doctor or investigator.

It is apparent that (a) is really only a part of (b). This is the key to why the false dichotomy in psychiatry has arisen. The patient's reports of his subjective thoughts and feelings are an important part of his observable reactions to, and interactions with, the doctor or investigator; they do not come from a separate realm to be distinguished from the body. Our concept of the "mind" is simply an "As-If" abstraction from these reports. "Changes in the mind" are "As-If" abstractions from changes in any of the foregoing data. How else, for example, could we speak of "repressed affect" when a patient's blood pressure rises in an aggravating situation, although he remains outwardly calm and denies any feeling of anger?

Can we say that the patient's "mind" has been changed when his depression lifts, for example, under the influence of placebo, of Tofranil, of EST, of psychotherapy? In all cases the answer has to be—by previous definition—yes. Therefore, the "mind" can be changed in psychiatry in a number of ways. Our explanation of this change depends upon our frame of reference. In fact, our patient's explanation of this change depends on the patient's frame of reference, which is sometimes quite different from ours and is often most interesting to hear. It is not correct to say that we are influencing the mind and not the brain, or the brain and not the mind, whether we give pills or somatic therapies or not. Psychological interaction must always take place between the patient and the doctor or investigator. To say we use drugs, for example, to make the patient "more accessible to psychotherapy" is definitely not *fundamentally* different from saying we are using it to "heal the sick patient's brain," in mental illness. The investigators in both cases are doing the same thing but using different frames of reference.

Good research is the basic activity needed to remove this confusion. Research means "that sort of activity which is directed to the accumulation of data that are useful for the purpose of prediction and control of observable phenomena. The phenomena with which the psychiatrist is concerned are largely those related

to the interpersonal activities of human beings. He wishes to be able to predict such behavior and where necessary for the patient, society, or both, to alter it."[5] Good research design and adequate knowledge of statistics are necessary for good research in psychiatry. No amount of esoteric language derived from any "school" can compensate for these features in a research report.

Good research has not been done to any large extent on any of the various methods used in psychiatry to "change the mind." A model example of any such research is given by Wikler.[6] The method under discussion is the use of carbon dioxide which, like the other techniques, has never been adequately studied. A useful model design based on the principles already discussed would be as follows: What are the comparative results of treatment:

(1) With carbon dioxide inhalation alone but including the unavoidable psychic interaction involved in the treatment setting?

(2) With inhalation of a gas known not to produce beneficial effects under the same treatment setting?

(3) With carbon dioxide inhalations plus a special, well-defined type of psychotherapy?

(4) With inhalations of a gas that produces no effect, as noted, plus a special well-defined psychotherapy?

Wikler writes: "Such a study might delineate the conditions under which carbon dioxide therapy is most effective, and its superiority or lack of it with respect to psychotherapy on the one hand, and the gas known to be 'ineffective' on the other. Indeed if statements of this sort could be made not only of carbon dioxide but also of all other drugs in clinical use and with respect to all measurable aspects of behavior, they would constitute definitions of 'drug effects' which would be serviceable both from the standpoint of exploratory investigation and of use in the clinic. Furthermore, they would render superfluous (if not meaningless) the interminable quarrels about whether an observed effect of a drug is 'real,' 'physical,' 'pharmacological,' or 'psychic,' whether it exerts a 'truly physiological' effect or 'merely opens up the patient to psychotherapy, etc., etc.' "

This paper is an attempt to take an objective look at the field of psychiatry as a whole. The basic problem in psychiatry is to change the mind. Because the mind is an "As-If" abstraction from the data of the doctor-patient relationship, it carries a danger of being personified and separated from the brain or the body as

a whole. This leads to descriptions of psychiatrists on the basis of their frames of reference, that is, whether they claim to influence the "mind" or the "brain," and carries a false assumption that psychiatrists are really doing fundamentally different things. Dichotomies of this nature are very dangerous and tend to become static, leading to misunderstanding and a lack of communication of information. They carry over into research, and impair the accurate evaluation of methods of changing the mind. The use of this dichotomy should be suspended and greater effort should be made to orient the practice and research of psychiatry to the fact that we are not dealing wih different entities, but merely different frames of reference. This would lead to the patient's getting the maximum benefits from all areas of psychiatry and to an improvement in the general tenor of psychiatric research.

Psychiatry Service
Veterans Administration Research Hospital
333 East Huron Street
Chicago 11, Ill.

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PSYCHIATRIC TRAINING FOR THEOLOGY STUDENTS: A REPORT

BY W. W. MEISSNER, S.J.

In recent years, psychiatry has co-operated more actively with religious personnel in attempts to utilize the resources of religion in the service of mental health. Ministers, priests and other religious leaders, on their part, have become more and more aware of the need of psychological and psychiatric information in the exercise of their pastoral duties. Consequently, religious personnel have become more directly involved in programs of active co-operation with psychiatrists. The role of psychiatry in this evolving relationship is for the most part educative. Psychiatric programs for training clerics have taken the shape of clinical training,[1] and for the most part members of the clerical profession have been quick to recognize that such programs have been beneficial[2-4] and even a necessary adjunct to the theological curriculum.[5]

However, such clinical programs are not readily adapted to the training of large numbers of priests and ministers. There is need, therefore, of educative programs which can provide the young cleric with a proper orientation toward psychiatry and provide him with the basic types of experiences and information which will serve him in his ministry. An experimental program of this nature has been attempted at St. Elizabeths Hospital in Washington, D.C. This article is an evaluation of the effectiveness of this program.

Program

The program in question was organized under the direction of Arthur H. Kiracofe, M.D., co-ordinator of clinical training, in co-operation with the Rev. Wilbur F. Wheeler and the Rev. Joseph A. O'Brien of the Catholic chaplain's office. The program consisted of nine separate days spent at St. Elizabeths. The days were spaced over alternate weeks so that the program lasted from the beginning of September 1960, to the middle of January 1961. The activities for each day lasted from 9:00 a.m. until 4:00 p.m. The morning sessions started with a lecture and demonstration, usually involving an interview between psychiatrist and patient before the group. The group was encouraged to ask questions of both psychiatrist and patient. The rest of the morning was spent

in direct contact with the patients on the wards. This was regarded as a most important feature of the program.

Members of the group were encouraged to get to know the patients, and hospital records were made available to them so that comparison of first-hand impressions gained on the wards and the psychiatric case records could be integrated. Members of the group were rotated through the various services of the hospital, spending an average of two weeks on each service. After the daily lunch recess, more time was made available for visiting the wards; the total time available for patient contact was about two and one-half hours. The final event for each day was a concluding lecture and question period, conducted by a staff member, usually a psychiatrist.

The morning and afternoon lectures and demonstrations covered the following subjects in this order: the role of the priest in mental health, signs and symptoms of mental illness, the major psychoses, psychoanalysis, individual psychotherapy, antisocial behavior, group psychotherapy, alcoholism and drug addiction, somatic treatment in psychiatry and research, paraphilias, psychology, brain disorders and senescence, social service and rehabilitation, problems of adolescence and childhood, psychoneuroses, and the history of psychiatry. A concluding period was reserved at the close of the program for discussion of the program, its evaluation by the participating group, and suggestions for future adaptation and improvement.

Subjects and Methods

The participating group consisted of 26 Roman Catholic priests in the terminal stages of their theological training. The age range of the group was 31 to 35 years; the median age was 32. Prior to the beginning of the program, the Loyola Test of Religious Attitudes[6] was administered to each participant. After the program was completed, the same test was re-administered. The test is a Likert-type test of attitudes toward psychiatry, composed of 35 statements. The responses are given in terms of a five-point scale of agreement or disagreement. The test includes a measure of subjective estimation of attitudes, in which the subject is asked to indicate his position on a line which stretches from "Strongly Favorable" through "Neutral" to "Strongly Unfavorable." These subjective evaluations were compared and ranked. Correlations between subjective measures and test scores were obtained for

each administration and for successive administrations. Comparisons of the mean responses before and after the program on each statement of the attitude test were made. The significance of the differences were tested in each instance.

Results

The mean attitude score shows an increase after the program over the mean score obtained from the 26 subjects before they began the program. The initial mean score was 122.7 and the final score was 131.2. The difference falls short of statistical significance at a level of confidence of 20 per cent. The shift toward a more favorable attitude would seem to be a result of the experiences in the hospital program. The changes in the subjects' self-evaluation and in the objective test score of attitudes are dealt with in the correlations of the table. Both self-evaluation and test score have about the same relation to the same measure after the program, as one might expect. But the relation of self-evaluation and test score before the program is closer than the same relation after the program.

Correlations of Before-and-After Test Scores on the Loyola Attitude Test*

	r	P
Test score before vs. test score after	0.41	.05
Self-evaluation before vs. self-evaluation after	0.43	.05
Test score before vs. self-evaluation before	0.54	.01
Test score after vs. self-evaluation after	0.34	.05

*Coefficients are computed according to the rank-order method and significance is determined by the t-test. See Edwards,[7] pp. 156-167.

Closer analysis of the changes in mean score for particular statements on the attitude scale give a clear picture of the direction of change affected. Changes which occurred at the 5 per cent level of confidence or better were the following:

1. A stronger feeling that a psychiatrist can be effective regardless of his religion.
2. A stronger feeling that current psychiatric practice does not allow expression of sexual impulses without moral inhibition.
3. A stronger impression that there is nothing in present-day psychiatry that is contrary to the teaching of the Roman Catholic Church.

4. A stronger feeling that psychiatry today is not dominated by a materialistic philosophy.
5. A stronger feeling that psychiatry is feared only because it is misunderstood.

Further changes were found, which did not reach the 5 per cent level of confidence, but which did fall between the 5 per cent level and the 20 per cent level. They are:

1. Greater disagreement over the contention that psychiatrists make people feel uncomfortable because they are always analyzing them.
2. Greater tendency to agree that psychiatry denies free will in human conduct through its emphasis on unconscious motivation.
3. Greater agreement that parishioners should be referred to a psychiatrist as readily as to any other medical specialist.
4. More disagreement about the proposition that in our society thorough knowledge of psychiatry is essential for the priest.
5. Greater feeling that psychiatrists often attempt to take the place of the priest.
6. Greater agreement that more emphasis on teaching the findings of psychiatry is needed in the seminary.
7. Stronger agreement that a priest should not hesitate to refer a parishioner to a psychiatrist.

Discussion

Evaluations of this nature are always extremely difficult because of the complex factors involved and our inability to measure accurately many of the important variables. Obviously, then, the statistical results do not tell the whole story. The general feeling, both on the part of members of the hospital staff and of the participating members of the group, was that the program was valuable and helpful. Most of the participants expressed highly favorable, and even enthusiastic, attitudes. The extent to which the results obtained here actually mirror attitudes and attitude changes remains problematic. The priests who participated in the program were favorably disposed to psychiatry to begin with. The initial test score of 122.7 compares to a neutral

score of 105 on this scale. The basically favorable attitude undoubtedly introduced a bias in the sampling of the group. The change in attitudes as measured was not radical, nor would it be expected to be. However, the significant and near-significant changes in attitudes in regard to particular statements indicate that, although attitudes are more favorable in many specifics, the shift is differentiating. Close contact with psychiatrists and psychiatric practice made these priests feel that psychiatry tends to under-emphasize free will, that they, as priests, do not need a thorough knowledge of psychiatry, and that psychiatrists often try to take the place of the priest.

The shift in attitudes is toward a more favorable view of psychiatry. One might question, however, whether the same results would be obtained in other clerical groups. Predisposing factors may have been operative in this group to swing the balance of judgment in favor of psychiatry. But even so, the reaction was mixed. This may be a reflection of basic points of view, on which some psychiatrists hold views differing from the religious convictions common to this group of clerics. It may be a reflection of areas in which greater mutual understanding needs to be developed between the psychiatric and religious professions.

In any case, psychiatry faces a problem of communicating its knowledge and spirit to a large group of professional workers whose pastoral concerns have an immediate relation to problems of mental health.

As the areas and levels of mutual contact and co-operation are enlarged, as they must be, psychiatrists will develop a better understanding of the function of the pastor of souls and of the possibilities of his opportunities for contributing to the control of mental disturbance. Meanwhile, we must experiment with means for increasing the scope and effectiveness of communication of psychiatric knowledge. The St. Elizabeths program is a step in the right direction. It offers the possibility of more effective contact with psychiatry for greater numbers of clerics.

Summary

An experimental program for introducing large numbers of theology students to the problems of mental illness and to psychiatry's approach to the solution of these problems is described. Evaluations of attitude changes in 26 clerics as a result of this

program are analyzed. The program was found to produce more favorable attitudes in general, but the change was not significant. Significant changes in particular attitudes were more mixed, but tended heavily toward more favorable attitudes to psychiatry.

Woodstock College
Woodstock, Maryland

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PRELOGICAL PROCESSES AND PARTICIPANT COMMUNICATION*

BY MAURICE R. GREEN, M.D.

This paper describes, with reference to the seminal work of William James and John Dewey, something of the transactional emergent quality of mental life. There will also be an effort to communicate here the clinical importance, stressed by the late Harry Stack Sullivan, of utilizing the marginal processes of conscious mental life more freely and fully,[1, p. 99] in order to tap the exceedingly rich manifold of transactional processes from which this conscious mental life emerges.[1-3]

Subthreshold Transactions

A powerful experimental tool for exploring these marginal processes has been the technique of observing and recording responses to stimulation that occurs below the threshold of reported awareness. There have been many, probably hundreds, of experiments on various aspects of subliminal perceptions over the past 75 years;[4-6] but the writer believes that the earliest one was conceived by Charles S. Peirce and carried out with the help of Joseph Jastrow over 75 years ago.[7] Peirce, the founder of American pragmatism and an indisputably eminent logician, stressed, in a chapter entitled "Prelogical Notions,"[8] the importance of understanding the preliminary unconscious cognitive processes for a proper appreciation of the human mind. He deplored the relative lack of scientific study in this area at the time (1893). Of course, unlike more romantic philosophers, he did not depreciate the role of logic for insuring successful and enduring communication. He published his experiment (probably poorly controlled by current standards) in 1883. It will be described later. Another very interesting experiment, encountered very recently, will also be described. This was reported by Edwin H. Land, the inventor of the Polaroid camera. These experiments clearly point up the well-known fact, confirmed repeatedly in many other experimental studies, that subthreshold registration occurs in an amazingly complex and efficient way.

Fisher,[10] Klein,[4] and many others[11] have been conducting investigations recently into the subthreshold processes, likewise noting the fact that meaningful response outside of awareness can and

*Presented to the Harry Stack Sullivan Society of the William Alanson White Institute, June 19, 1959.

does occur. The experiments by Peirce and by Land relate more to a physiological conceptual framework than to the interpersonal clinical orientation of this author; but transactional interpersonal processes occur also at this physiological level and may or may not emerge later into relatively ordered conscious thought. The recent experimental studies just mentioned are closer to the clinical context. They show that the responses given by the patient express, not only the unwitting influence of the subthreshold material, but also the patient's own personality pattern. Such patterns shape the structures of symptoms and dreams. Some of the investigators apply the Freudian instinct theory in their attempt to explain the conditions that govern what material does and does not enter awareness. However, what the author considers to be the limitations of their theoretical approach do not necessarily vitiate the value and significance of their work, which has to be appreciated on its own merits.

Nature of Consciousness

Not only are the imagery, concepts and other phenomena of mental life emergent from ongoing interpersonal processes outside of the possible grasp of our focal awareness,[12] but these very phenomena themselves also are shaped at the moment of their happening by their meaning in the context of our personal histories, appetites, problems, and concerns. Furthermore, it has become increasingly evident that logic has relatively little to do per se with consciousness as such. Certainly logical structure does not characterize consciousness any more than, say, magical structure or superstitious structure. Neither is consciousness required at a given moment for the operation of logic. One can quite unwittingly follow a logical method in arriving at a truth that occurs out of the blue, so to speak. And it is well known that logical mathematical operations can be performed in dreams. Therefore, consciousness must be described functionally, as James discovered, as a stream of fields of awareness, the contents of which may or may not conform in varying degrees to the canons of logic.

The contents of consciousness appear in a central focal area, always changing, while the margins, too, change, expand and contract. The contents of consciousness represent not only the past of a person, but also to varying degrees current and future

activity and experience of the world. This experience always includes data originating from within the integumentary boundaries of human skin, the so-called inner world, as well as data originating from beyond these boundaries, the so-called outer world. The very fact of subthreshold registration of meaningful data indicates the relatively heuristic significance of these "inner" and "outer" categories, thus emphasizing the transactional processes from which these categories are constructed.

Consciousness and Playfulness

Insects, birds, and animals manifest an elaborate and highly efficient instinctual apparatus for correlating appropriate activity, need-tension and information between their "inner" and "outer" realms. Man's instinctual apparatus never gets beyond a rudimentary and immature development, for he has inherent symbolizing equipment which is not so restricted by need-tensions and adaptive requirements of the moment. As Schachtel points out,[15] it is this very freedom from urgent need that allows for the play, exploratory curiosity and creative elaboration that characterize the many-faceted phenomena of childhood experience. Piaget also stresses the importance of play.[14] This play, exploration and curiosity, so characteristic of the young child, is also manifest in the creative and spontaneous moments of adult life, in dreams, daydreams, artistic activity, recreation, and even scientific research. In fact, as Johan Huizinger indicates in his work, *Homo Ludens* (*Man the Player*), play is the very life stuff of civilization and culture.

The state of consciousness during play is filled with the content of the playful activity itself. Focal awareness moves freely within the rules of the activity, free from external coercion, force or restraint; not free, of course, from effort, perspiration or tension. The term playful is used to characterize attention that is either freely roving or fixed; but it is applied here to fixed attention only when such attention is fixed by the genuine response of the person to something novel, that is, so to speak, intrinsically inviting his attention. The situation is not playful when the attention is submitting to some external compulsion, but is playful only when it is submitting to a spontaneous, self-initiated response.

Sometimes in a very serious discussion a questionable idea arises, and we say, "Let's play with it for a while; let's kick the ball around." That is to say, let us not dismiss it, even though

it does not yet stand up to criticism from without. Let's explore it further in other aspects and implications. Thus we open our awareness and expand the margins of our consciousness beyond the narrow focus required for rigorous validation and criticism. This allows our imagination to exploit the wider dimension of our experience, which includes subthreshold data of marginal and unnoticed transactional processes between ourselves and others.

Considering the findings on subthreshold processes, the nature of consciousness, and the requirements of the difficult task of psychoanalytic investigation, it seems that it might be possible to provide a logical method or rationale for exploiting these marginal and subthreshold transactional processes of perception, including those of the analyst as well as those of the patient; and that, in consequence, the spontaneity of the analyst might be facilitated.

Experimental Studies of Subthreshold Transactions

Consider the experiments of Peirce and Land.

In 1883, Peirce, American philosopher and scientist, published a paper, considered by Boring[15, p. 529] to be of fundamental importance, entitled "On Small Differences of Sensation," describing an experiment that he made with Jastrow to test Fechner's Law—namely, that two nerve excitations alike in quality only produce distinguishable sensations, provided they differ in intensity by an amount greater than a fixed ratio. Peirce tested this by using pressure stimulation from a set of graduated weights.

Peirce had the subjects state their judgments of the difference in two sensations, and this was expressed as an increase or a decrease. At the same time, the subjects also gave measures of the degrees of confidence that they had in their judgments on a scale from 0 to 3. Peirce postulated that rather than the existence of a least perceptible difference of sensation, according to Fechner's Law, the judgment of change in sensation would follow the probability curve, which expresses the law of an effect brought about by the sum of an infinite number of infinitesimal causes. In other words, Peirce predicted that the multiplication of observations will indefinitely reduce the error of their mean, so that if one of two excitations were ever so little the more intense, it would be judged in the long run to be *the* more intense the majority of times. A thousand trials were made, and Peirce's prediction was borne out.

In the course of this experiment, Peirce noticed that the subject often was not aware of any difference in sensation and expressed this as a confidence of zero in the judgment that he gave. But, at the same time, the judgment itself was correct, often as much as three times out of five. He concluded, "The general fact has highly important, practical bearings, since it gives new reason for believing that we gather what is passing in one another's minds in sensations so faint that we are not fairly aware of having them, and can give no account of how we reach our conclusions about such matters."[7, p. 27]

Recently, a series of studies on color perception was done by Land. He projected, superimposed on the same screen, two black and white transparencies of the same scene, taken through the two lenses of a dual camera: (1) a transparency taken through a red filter and projected through a red filter, and (2) one taken through a green filter and projected by plain white light. He found that a subject would see the full range of natural color, covering the entire spectrum, in the scene on the screen. In this way, Land disproved the classical theory of color perception established by Newton and Helmholtz. According to the classical theory, color perception was based on wave lengths from the red, green and blue bands of the spectrum, and the eye had to respond to vibrations in varying degrees of strength from these three different bands to see the full range of color. Now Land has demonstrated that colors in a natural image are determined by the relative balance of long and short wave lengths over the entire scene, assuming that the relationship of these wave lengths to each other changes in a somewhat random way from point to point. This randomness, by the way, is essential for the experience of natural color. Says Land:

> The independence of wavelengths and color suggest that the eye is an amazingly versatile instrument. Not only is it adapted to see color in the world of light in which it has actually evolved, but also it can respond with a full range of sensation in much more limited worlds. . . .[9, p. 93]
>
> . . . what the eye needs to see color is information about the long and short wavelengths in the scene of its viewing. It makes little difference on what particular bands the messages come in. . . . The eye-brain computer establishes a fulcrum wavelength; then it averages together all of the photographs on the long side of the fulcrum and all of those on the short side. The two averaged pictures are compared, as real photographic images are compared, in accordance with our coordinate system.[9, p. 96]

This indicates that subthreshold registration occurs in a series of discrete instants in minute fractions of time, much like the concept of prototaxic experience described by Sullivan.[12, pp. 28n, 76]

Comment

These two experiments, spanning a period of roughly 75 years, indicate a remarkably complicated and efficient subthreshold registration of the elemental data of interaction. (Furthermore, they seem to follow probability statistics rather than a linear mechanistic formula.) It is these subthreshold processes and other nonconscious mentation that Peirce believed should be the main body of psychological study. He said: "Mind, on the contrary, when you once grasp that it is not consciousness nor proportionate in any way to consciousness, is a very difficult thing to analyze. ... To get such a conception of mind, or mental phenomena, as the science of dynamics affords of matter, or material events, is a business which can only be accomplished by resolute scientific investigation."[7, p. 226]

In 1902, in *Varieties of Religious Experience,* James[16] had some pertinent remarks to make on the notion of fields of consciousness. He stated that it was here, in the field of consciousness, that the flowering takes place of motives which have previously ripened and matured in their subconscious incubation. He said:

> Until quite lately the unit of mental life which figured most was the single idea, supposed to be a definitely outlined thing. But at present psychologists are tending, first, to admit that the actual unit is more probably a total mental stage, the entire wave of consciousness or field of objects present to the thought at any time; and, second, to see that it is impossible to outline this wave, this field, with any definiteness.
>
> As our mental fields succeed one another, each has its center of interest around which the objects of which we are less and less attentively conscious fade to a margin so faint that its limits are unassignable. Some fields are narrow fields and some are wide fields. Usually when we have a wide field we rejoice, for we then see masses of truth together, and often get glimpses of relations which we divine rather than see, for they shoot beyond the field into still remoter regions of objectivity, regions which we seem rather to be about to perceive than to perceive actually...
>
> The important fact which this field formula commemorates is the indetermination of the margin. Inattentively realized as is the matter which the margin contains, it is nevertheless there, and helps both to guide our behavior and to determine the next movement of our attention. It lies around

us like a magnetic field, inside of which our center of energy turns like a compass needle, as the present phase of consciousness alters into its successor. Our whole past store of memories floats beyond this margin ready at a touch to come in; and the entire mass of residual powers, impulses, and knowledges that constitute our empirical self stretches continuously beyond it. So vaguely drawn are the outlines between what is actual and what is only potential at any moment of our conscious life, that it is always hard to say of certain mental elements whether we are conscious of them or not.[16, p. 186]

Dewey[17] in 1925 stated that perception is not inherently different from other modes of consciousness, such as emotion, thinking, remembering and imagination.[17, p. 318] He said:

There is indeed much to be said for the view that consciousness is a dreamlike, irresponsible efflorescence, and that it gains reference to actual events in nature only under compulsion, and by way of accidental coincidence. There are elements of truth in this view, as against the orthodox tradition which makes consciousness architectonic, having righteous and rational conformity as a cornerstone of its structure.[17, p. 343]

. . . to partake and to perceive are allied performances. To perceive is the mode of partaking which occurs only under complex conditions and with its own defining traits. Everything of importance hangs upon what particular one of the many possible ways of partaking is employed in a given situation. . .[17, p. 345]

The organism, wherever possible, participates *à son gré*: its taste and bias are conditioned in the degree of its susceptibility and retentiveness, upon prior satisfactions. The union of past and future with the present manifest in every awareness of meanings is a mystery only when consciousness is gratuitously divided from nature, and when nature is denied temporal and historic quality. When consciousness is connected with nature, the mystery becomes a luminous revelation of the operative inter-penetration in nature of the efficient and the fulfilling.[17, p. 352]

The use of the term consciousness to denote the various degrees of accessibility to awareness should be differentiated from the use of the same term to denote the actual content of the field of awareness, however vague its boundaries might be. This content of consciousness can be described in three categories. The author believes the three described by Peirce in 1867, together with the modes of experience described by Sullivan more recently, provide a most useful frame of reference, albeit a crude one, for studying the relationship of the total experience of organismic interaction to the field of awareness, and for avoiding a solipsistic ego psychology. Peirce described the three categories of firstness, second-

ness and thirdness, each one of which is a necessary condition for a conscious experience.

Firstness is the immediate feeling as such, without discrimination, association or similarity—the total immediate instant of experience. This cannot be sustained for any time; and it cannot be reflected upon or thought about, a process that falls at once into the category of secondness. Secondness refers to the experience of brute fact, of thisness and thatness. Brute fact describes the contrast of past with present, of black with white; whatever subtle gradation or change or difference there may be, the contrast is nonetheless a fact that can be seized upon, that has an impact on immediate awareness. Peirce's category of thirdness is that of meaning, by which facts are related to other facts in time and space, in association of similarities, differences and classes, sets or forms of relatedness. It is only by these forms, sets, signs, representations, that there can be a meaningful experience.

Sullivan described three modes of experience from which mental activity is elaborated, the prototaxic, the parataxic, and the syntaxic. He defined them as follows:

> The prototaxic, which seems to be the rough basis of memory, is the crudest—shall I say—the simplest, the earliest, and possibly the most abundant mode of experience... The prototaxic, at least in the very early months of life, may be regarded as a discrete series of momentary states of the sensitive organism, with special reference to the zones of interaction with the environment... It is as if everything that is sensitive and centrally represented were an indefinite, but very greatly abundant, luminous switchboard; and the pattern of light which would show on that switchboard in any discrete experience is the basic prototaxic experience itself, if you follow me. This hint may suggest to you that I presume from the beginning until the end of life we undergo a succession of discrete patterns of the momentary state of the organism, which implies not that other organisms are impinging on it, but certainly that the events of other organisms are moving toward or actually effecting a change in this momentary state.[12, p. 29]

This seems to be in accord with the thought of Peirce and Land, suggesting a basic ground of discrete momentary experience for later symbolic elaboration.

The parataxic mode begins with generalizing from this experience in the prototaxic mode. This development is inherent in psychobiological maturation. Sullivan said:

Generalizing, then, is a particular development in the identifying of differences; it is, we might say, what is left of things that are similar when the differences have been identified. In other words, the forms of experience are generalized so that things in common in them, as well as all of their sundry differences, are in perception as useful experience. These influxes of experience are marked by any one of several zones of interaction. . . [12, p. 83]

The identifying of differences can make very useful contributions to behavior in the satisfaction of needs; and the generalizing of experience so that the significant common factors mixed in with the differences are identified or connected with one recurrent pattern of experience, primarily mediated by the distance receptors, elevates the complexity or elaboration of experience from the prototaxic to the parataxic mode of experience.[12, p. 84]

This parataxic experience begins early in infancy and predominates throughout childhood and the length of one's life. It is in the parataxic mode of experience that the elaboration of one's awareness of the person one refers to as one's self and of one's awareness of other persons in one's life begins to develop. This mode corresponds more or less to the preliminary intuitive states or prelogical states—the elaborations of feelings and thoughts that are not ready yet for enduring memory or communication to others. Thus, one can see that the parataxical mode of experience covers a very wide range from autistic referential processes in the private mode to the creative intuition that has not yet become fully realized for communication or expression in a more public mode of experience. Sullivan referred to the dream and myth as manifestations of valid parataxic experience. Statements that evoke this same parataxic experience in others would be in the syntaxic mode.

To the extent that experience does achieve its full form and is ready for more or less precise communication or sharing, it approaches what Sullivan called the syntaxic mode of experience. (The prototaxic mode of Sullivan seems to bridge the first two categories of Peirce. The parataxic and syntaxic would enter Peirce's third category.)

Sullivan said:

In fact, the first unquestionable organization of experience in the syntaxic mode is in the realm of the two great genera of communicative behavior, gesture and speech. . . A consensus has been reached when the infant or child has learned the precisely right word for a situation, a

word which means not only what it is thought to mean by the mothering one, but also means that to the infant. Incidentally, an enormous amount of difficulty all through life arises from the fact that communicative behavior miscarries because words do not carry meaning but evoke meaning, and if a word evokes in the hearer something quite different from that which it was expected to evoke, communication is not a success.[12, p. 183]

These classifications of Peirce and Sullivan are rooted respectively in the philosophy of pragmatism and the interpersonal theory of psychiatry. Sullivan tended to place most of his emphasis on the rational discursive processes that were involved in communication as a mutual evoking and sharing of meaningful experience. Logical propositions, that is, verbal statements that follow the rules for precise communication, obviously have a great advantage for insuring that such communication is successful. This fact has led logicians and philosophers, such as Professor Carnap, to state that *only* such discursive statements have any status as truth or knowledge. Hence, they rule out of their domain of the knowable the entire realm of desires and satisfactions, feelings and hunches, and the kind of communication and sharing that has been referred to in the work of Peirce, James, Dewey, and many others. Such a narrowly rigorous insistence on discursive inquiry, along with a premature application of these criteria to human interaction, has been a grave limitation for the realization of the full potentialities of psychoanalytic methods in the understanding of man and the cure of his illnesses.[18] In this regard, it is important to understand other forms of knowing and sharing than the logical discursive propositions.

There are forms of communicating feeling, fairly precisely, in sounds such as music and poetry; and there are visual forms, such as lines, colors and proportions, which are also capable of rather precise articulation and communication[18]—of elaboration from the parataxic toward the syntaxic mode. Visual forms, for example, are very important because they occur so frequently in psychoanalytic work and in other creative activity. Since visual forms present their full complexity and interrelationships simultaneously, in a given instant of experience, their complexity does not need to be limited—as that of discourse is limited by what we can retain in attention from the beginning of a statement to the end of it. Ideas that are too complicated and interrelated,

with many relations within relations, cannot be presented in a simple discursive statement.

Furthermore, propositional statements have primarily a general reference to names, classes, categories and more abstract categories and classes of information, whereas a picture or, to put it more generally, a presentational form, which can be communicated directly, has a much more specific, concrete and immediate reference, whether it be a photograph, a movie, or a simple image that is aroused by a poetic statement. The dream and daydream and other such forms are very valuable to us for this reason. Sharpe[20] demonstrated that the so-called laws of the unconscious that were described by Freud are actually the very rules of poetic diction or image formation that had been formulated and described for hundreds of years previously by writers on aesthetics.

Silberer stated many years ago, in his work on hypnogogic hallucinations, that the image was a very valuable instrument for grasping something that was too new or complex yet for a full command of its idea.[21] Hence, it is important to give latitude and range for the development of such imagery, which is so valuable for discovering the greater and not yet known reality of our experience with each other.

Considering the complex intricacy of this experience and all of the richness inherent in it at any given moment, it is remarkable and puzzling that our imagery is actually successful in evoking feelings similar to our own in other persons. But it is only puzzling when one is confused by the myth of the isolated, gloriously unique individual. Man is not creative, out of his separation from nature and other persons; that is the path to mental derangement and sterility. Man is creative out of his vital participation in nature and the lives of others. Interpersonal refers to an existential aspect of man, not to a mere social qualification. When we see people participating in the same reality, it is not puzzling that one's unique personal experience of a poem or a dream is both in agreement with, and different from, that of others. It is at this point that the movement of the creative process from its subliminal depths of unnoticed participation, and from the private reverie or sleep, has achieved its fullness in the shared interpersonal experience.

Premature interruption of the creative process by critical scrutiny, like the premature interruption of the perceptual process

by critical scrutiny, may interfere with its emergent growth. This growth is not created out of an isolated entity called ego, mind, or self. It is created, as the self was created, out of the substratum of human participation and response; and it is guided, organized, elaborated from the parataxic to the syntaxic mode of experience under the direction of a self whose continuity extends indefinitely beyond the margins of attention and recall.

The parataxic experience of the therapist can be fruitfully communicated to the patient in a spirit of playful but serious inquiry. The therapist's dream, not only the dream of the patient, can grasp more of the patient's life than either one is conscious of. The character structure and transference relationship, as Thompson pointed out,[22] are not fixed internal structures, like an encysted, inspissated foreign body. The character structure and transference are a continuity of structural on-going processes, recurrently manifest again and again in very subtle or even crude ways in everyday interpersonal contact.[23] Thus the therapist, although he may not notice it, is very quickly involved in a very complex interpersonal transaction. It is impossible for him to pay rigorous attention to more than a minute segment of this at any particular time, let alone even recall all that he has noticed. But, nevertheless, in the course of time, he has taken in—registered beyond the margin of his attention—a great deal of the patient's past, present and future way of living. Hence, by presenting his dream to the patient, he can often, in the ensuing exchange, bring some relatively unnoticed material into bold relief. His dream, like his hunch, intuition, reverie or guess, is not completely random, but emerges out of his dedicated involvement in meeting the challenge of his patient's tragic life struggle.

Clinical Illustration 1

A patient, a chubby, worried young man, had dropped out of college in his second year after a generally satisfactory though not brilliant academic record. He was not able to work well because of depression and obsessive rumination following a love affair. I saw him a year later. He complained of depression, irritability, fear of insects and dogs, and vague aches and pains. In the course of time we worked out a considerable understanding of the difficult, complicated family he had grown up in, and how he had come to have the trouble he had. He had calmed down a

good deal and was working steadily. But there was a kind of apathy I could not understand. I felt that there was something missing in his response which I could not explain. Then I had a dream:

In the first part of it, I dreamt of having a conversation with him. During this conversation he hallucinated a figure named Jim, to whom he paid attention, while ignoring the perfectly sane, sensible remarks I was addressing to him. Suddenly the scene changed; an old watchtower that belonged to his college dormitory, which he had admired very much, was crumbling and decaying. Children came at night to break the windows and mark up the walls. I then realized that the patient himself was the watchtower, and that he was secretly convinced that his mind and body were deteriorating, and that other people were only interested in exploiting his weakness and helplessness for their own sadistic pleasure.

The patient was really terrified of me and of the world at large. This gradually became overt after his defensive apathy was first penetrated by telling him my dream and what it said to me. He was warily watching "Jim," a potentially dangerous fellow, while going through the motions of talking with me.

Clinical Illustration 2

A young artist came to me complaining of difficulty in his work, uncontrollable tantrums, and exaggerated feelings of shyness, weakness and inferiority. We seemed to make steady progress, but I felt there was something peculiar in his response to all interpretations and to the analysis of his feelings of littleness, fears of castration, and so on. At one point he was saying that he was working so hard at representing a certain notion in a work of his that he was afraid he would drive himself "crazy" with it. The thought occurred to me out of the blue that I should say to him, "The least you can do is to risk going insane. After all, just think of how many people died for their ideas." This thought certainly did not express my own opinion, but I told this to him to try to find out what it was about. He replied, "Yes, I know. I am always indulging in feeling sorry for myself. I hate myself for it."

I now realized that this man was constantly disparaging and belittling himself in comparison with various heroes and martyrs.

What I had failed to grasp previously was the subtle grandiosity of this anxious preoccupation. The thought that occurred to me out of the blue expressed the unspoken grandiose attitude of the patient himself toward what he had been saying. We could now explore the unreported wish that he had for heroic martyrdom, a wish implicit in his reported fears of littleness and castration.

Summary

Two clinical examples of the use of prelogical processes in therapy show dynamic insight that seems inevitable, but that is always true *after* the insight is achieved. The event may seem dramatic but only in a context where the therapist is afraid to reveal himself; otherwise it is simply human. It is the human importance as well as technical effectiveness that marks the clinical significance of these prelogical processes. Transactional interpersonal processes must be considered together with the hierarchical order of the modes of experience in the stream of consciousness in order to exploit fully the wider margins of our mental life with one another. This paper discusses the nature and manifestations of prelogical processes, and their place in the heirarchical order, and gives a review of some of the pertinent literature, with particular attention to Charles S. Peirce, William James, John Dewey, and Harry Stack Sullivan.

985 Fifth Avenue
New York 21, N. Y.

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AN ANTHROPOLOGICAL APPROACH TO RESEARCH IN THE MENTAL HOSPITAL COMMUNITY*

BY DAVID LANDY, Ph.D.

This paper is devoted to two subjects: (1) the role of the anthropologist as researcher in the mental hospital community in the light of the social and cultural characteristics of a small, state-sponsored, short-term treatment hospital;** and (2) some problems encountered in doing action research in such a hospital as part of an interprofessional team. Since the first subject has been discussed at length elsewhere, the writer will attempt here only to offer a brief summary of his own views about the anthropologist in the mental hospital community and proceed forthwith to the problems of interprofessional research in such a setting.

The Anthropologist in the Mental Hospital Community†

In recent years anthropologists have become involved in a great variety of assignments as researchers and actionists in various institutions of Western societies. One of these institutions is the mental hospital. The writer's own assignment has been to plan, direct and execute research into the total rehabilitation of the mental patient. His orientation was to consider the process as a problem in acculturation and learning for the patient and his rehabilitators in a series of potentially disjunctive subcultures: community to hospital, to transitional rehabilitative status, and back to community.‡

The concept of the mental hospital as a "therapeutic community*** has certain implications for the anthropological researcher.

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**Massachusetts Mental Health Center, Boston.

†This section is a summary of Landy, David: The anthropologist and the mental hospital. Human Organ., 17: 30-35, Fall, 1958.

‡Landy, David: Psychiatric rehabilitation: an acculturative process. Paper read to American Anthropological Association, Washington, D. C., November 1958.

***Jones, Maxwell: The Therapeutic Community. Basic Books. New York. 1953. A series of studies of aspects of Jones' community by anthropologists who have studied it—particularly Robert Rapoport and Seymour Parker, as well as Jones himself—has been appearing.

The aims of the staff (to get the patient well), of the patients (to get well), and of the researcher (to arrive at some approximation of the objective situation, or "truth"), are not necessarily compatible, and built-in strains in the hospital structure may be aggravated by the presence of the anthropologist, who may be perceived as another competitor for "a piece of the patient." Staff, patient and researcher are motivated by complex manifest and latent values which may facilitate or impede the implementation of their institutional goals.

Certain differences between the therapeutic community and other types of communities must be understood by the anthropologist. For example, the therapeutic community is interested in constantly moving out its population, the total society is interested in maintaining its personnel; the former is essentially a professional society, the latter contains a greater multiplicity of orientations; staff members and researchers live out of the therapeutic community, and orientation of the patient is outward toward his community of orientation.* Professionalism in this type of hospital pervades the total staff from maintainance to medicine. It stimulates certain concerns, including some rivalry with the researcher, and some nonrational needs that do not necessarily concern the welfare of the patient, for example, the enhancement of prestige and the exercise of power and authority. Unlike his role in the usual community that he researches, the anthropologist here is only one of many experts. He may be caught, not only in the struggle for status and power, but in the ideological split between psychiatrists and other clinicians who are oriented toward the primary importance of the psychotherapeutic relationship and those who favor a more total-environmental approach to therapy.

The anthropologist is perceived in varying ways, not only by different levels of staff and by patients, but within these levels by individuals according to their personal perceptual needs. Functioning in an action situation analogous to interdisciplinary research, he finds he may be considered an expert on all aspects of social science. Furthermore, the stereotype of the social scientist held by hospital personnel makes little distinction between the various breeds, for instance, anthropologists, sociologists, social psychologists. Because of pressure in this action situation for

*Landy, David: Cultural antecedents of mental illness in the United States. Soc. Serv. Rev., 32:350-361, December 1958.

immediate feedback of information concerning the patient, the luxury of leisurely contemplation of observational and other data after leaving the field may have to be surrendered. The anthropologist's work, particularly his role as observer, is one fraught with ambiguity for members of the therapeutic community, though in this respect it is not unlike anthropological field work experience in cultures everywhere.

Advantages and disadvantages are inherent in the expectations held by the patient in the hospital. Unlike his community of orientation, he learns to expect little in the way of privacy for intimate personal details, and this may facilitate research into vital areas. On the other hand, this limits the participant aspect of observation considerably, unless the anthropologist wishes to use the guise of patient or of staff member, either of which seems potentially more upsetting than an overt assumption of the observer role. The experience of Caudill is dramatic proof that the traditional approach to the observer role is the most efficacious.* Furthermore, while much of the patient's private life is bared to the hospital public, the patient may always exercise the right to be ill, and to resist intrusion of outsiders by acting-out or acting-in behavior. That is, he may so distort his responses, both to observer and interviewer, that the researcher will not know how much to charge to illness per se and how much to deliberate resistance.

The problem of "affective-neutrality" becomes serious for the anthropologist in the mental hospital, since patients and staff come from his own general culture; and pressures to identify with them come from within and without. And the fact that the patient's illness may be seen as culturally caused, may, to some degree, stimulate feelings, latent in the anthropologist, of intellectual or romantic discontent with his own culture.

This, then, is in summary the view of an anthropologist in a particular mental hospital. Now let us turn to some of the problems encountered in working as a member of an interprofessional team. Some of these are problems that would confront the anthropologist as such; some would confront any social scientist dealing with these particular research questions and in this particular setting. Some are generalizable to hospital research everywhere;

*Caudill, William: The Psychiatric Hospital as a Small Society. Harvard University Press. Cambridge. 1958.

some may have specific relevance only to the writer's own experience.

The Method of Participant Observation

First let us look at the principal technique of the anthropologist: the participant observer method. This method has been used in several phases of the mental hospital project undertaken by the writer: in two ward studies, in studies of a so-called "halfway house" or transitional community residence for discharged patients, in an expatients' club, and in studies of the hospital work program. Understanding this method is important to anyone who wishes to collaborate with the anthropologist. Yet its implementing technique and rationale, as well as the data which emerge from its use, are not readily understood by members of the team with whom the anthropologist must interdigitate his efforts.

Essentially, the method consists of the anthropologist literally taking up residence—or doing so as much as is practicable—with the group which he wishes to study. He attempts to partake of, and participate in, the life of the group, and while he usually makes it quite clear that he resides with the group in order to study its ways, he tries to become accepted by its members. However, under no circumstances does he "go native," though he makes every effort to approach the society without rigid preconceptions and to see life from the viewpoint of the native. While he is perhaps something of a threat at first, in the same way that a stranger in any group becomes an unknown phenomenon, he comes to be accepted sooner or later as someone with a job to do, and in most instances is left alone to do it.

Occasionally he may help someone with a task, but in general he does not feel uncomfortable about his role. The fact that he will at times appear to be doing nothing more than watching other people is not something with which he concerns himself. Actually he is trained to observe all that goes on within his ken, and to make frequent and careful inquiries of a whole range of informants about the phenomena he experiences, questioning about what is present and what is absent. Informants who seem to be well-qualified with knowledge of the culture and who are willing to supply information, he will often use intensively. This is the so-called key informant technique. With observation and interview, he hopes, before he leaves the field, to tap the practices and values of a representative variety of persons. Through their frequency,

intensity, and temporal-spatial distributions, he will attempt to discern the ways in which such practices and values arrange themselves into patterns of culture.

It is doubtful whether the increasing number of hospital organizations that hire anthropologists to do research realize the elements of the major methods of anthropology or their implications. Since their previous acquaintance with anthropology may have been limited to reading a popularized book on the subject, this is understandable. Therefore, the author will discuss some of its implications, which, in the nonanthropological mind, may seem to be of the order of romantic accounts of idyllic, exotic cultures.

The method is most successful with relatively small groups of people: that is, several hundred or at the most a few thousand. It is essentially a configurational approach and is the only one which is capable of dealing with the culture of a total small society. It is based, not alone on intuitive impressions, though these often provide the anthropologist with crucial insights, but upon the hard data of direct observation and interview. These data are gathered and filed systematically, and arranged into a set of categories which usually expands to several times its original size by the time the field work is completed. Usually the anthropologist has in mind one or more theoretical models which underlie the conceptual framework across which he will ultimately place his data. In most instances, he will spend his first weeks or months trying to perceive at least some of the main outlines of the cultural skeleton. Then, gradually, he fleshes in the skeleton, from time to time making alterations in the patterns he first perceived, as new areas of community life become available and his fund of information grows. After he thus has the "ethnographic feel" of the culture, he will proceed to gather more focused data aimed at testing hypotheses or answering specific research questions. By this time his inquiries may be more fruitfully researched within the context of his cumulative knowledge of the culture that he has thus begun to experience. His final portrait of the society will be painted after he has left the field and carefully analyzed and assessed his findings.

This method has something in common with that of the clinician. He, too, approaches his subject with certain conceptual models in mind. He, too, attempts to gain rapport with the subject and to understand his view of the world, as well as the characteristic

ways in which the subject thinks and behaves. He, too, finds that his basic instrument is himself; and a favorite phrase of psychiatrists and psychiatric caseworkers is "use of the self." The clinician's data are thus obtained from listening to, speaking with, and observing the subject, using himself as the mediating instrument. Despite the widespread use of projective techniques and other psychological tests, he usually feels he can depend most strongly upon the data which have been recorded through his interpersonal transactions with the patient. Furthermore, he does not feel that such data are easily quantifiable, and often finds that they defy statistical analysis.

Yet, strangely enough, the clinician may sometimes feel that the observational data of the anthropologist have limited usefulness because they are "merely descriptive." Or, he may feel that the data can only be useful if they are quantified, and some have told the writer that they cannot accept the validity and reliability of unquantified data. Now the writer has no bias against quantification; in fact much of his work at the hospital where this study was done and elsewhere has been based upon quantitative methods. Nevertheless, just as the clinician uses himself as his own best recording instrument, the anthropologist must rely ultimately upon his own observational data, though he may want to buttress them in various ways with data gathered through other means, for example, interviews and projective techniques.*

Furthermore, it is possible to obtain observed data which are focused and specified so as to render them quantifiable, or even to use pre-coded categories within which to place them, so that later they may be scaled and thus measured quantitatively. But this point aside, observational data gathered by a trained anthropologist with the usual precautions for field validation (checking field results against each other and through a series of informants) seem to the writer to be just as valid as any other kind. In fact, the opportunity to check data in the field with further observations of similar behaviors affords anthropological data a rare kind of validity not easily obtained through the use of other methods.

*Landy, David: Methodological problems of free doll play as an ethnographic field technique. In: Selected Papers of the Fifth International Congress of Anthropological and Ethnological Sciences, A. F. C. Wallace, editor. University of Pennsylvania Press. Philadelphia. 1959. See also Henry, Jules: Projective testing in ethnography (with comments by others). Am. Anthrop., 57:245-270, 1955.

Use of Service Personnel as Researchers

There is often a tendency in the hospital to use existing personnel as research personnel also. From the administrative point of view this is often considered desirable since it may mean a raise in pay and prestige for the individual, and thus "promotion" within an organization which contains relatively few opportunities for vertical mobility.* It may also be felt, both from the viewpoint of administration and the viewpoint of the research team, that hiring personnel from the existing staff, though its members may have had little or no training or experience in research, is desirable, since it will aid in alleviating feelings of estrangement between hospital staff and research staff. Perhaps the service staff will feel more kindly toward the research staff if some of their number are among them; and perhaps the latter can thus come to know the service staff more intimately.

Generally this does not seem to have worked out with much success in the writer's project. For example, three social caseworkers who joined the staff as researchers resigned after a few months. At least two of the three felt uncomfortable with research methods and requirements. Similar experiences with persons trained primarily as practitioners have occurred in other research projects. Since the training, orientation and predilections of such practitioners are in the realm of service, it is not surprising that they did not feel at home in the roles of researchers.

It became strikingly apparent that untrained persons could not be used in research capacities unless there could be on-the-job-training, for which the drain in time was found to be uneconomical. One exception is that, with some supervision, a student with a bachelor's degree but previous research experience has been able to carry out interviews and some data analysis. The untrained person has been unable in particular to fill the role of participant observer. The writer's project had occasion to use three participant observers. Two were trained anthropologists who were able to move comfortably in the role and gather much valuable and systematic data. The third was a young man who was getting a graduate degree in psychology and had been working as an attendant at the hospital. He was interested in research, and it was felt that

*Smith, Harvey L., and Levinson, Daniel J.: The major aims and organizational characteristics of mental hospitals. In: Greenblatt, M.; Levinson, D. J., and Williams, R. H.: The Patient and the Mental Hospital. Free Press. Glencoe, Ill. 1957. See also, Parsons, Talcott: The mental hospital as a type of organization. Ibid.

his experience as a psychiatric aide would be invaluable. However he never felt comfortable in the role of participant observer. He could not rid himself of the feeling that he was "spying" and "informing" on the very people whom he had known as staff members and patients, and after several months in the role he resigned. Some of his data are being used, but in general their usefulness was impaired by his lack of training and knowledge of how the observer gathers his data, and by his inability to accept the role.

Problems of Controlled Research in the Hospital Organization

Another problem that the anthropologist has to deal with is the need for control or comparison groups. This problem inevitably arises when the social scientist or the clinician is called upon to evaluate results of a particular treatment or rehabilitative procedure. The use of a control group is intrinsic to the classical experimental model for deciding whether change is due to chance factors or to the variable which has been manipulated. Now, ordinarily in his researches, the anthropologist is not called upon to evaluate experimental change, except perhaps changes which may occur as a result of administrative procedures in a colonial society, in which case the usual task is to see to what degree they are consonant or conflictual with the society's traditional and contemporary practices and values. True, in recent years, anthropologists have occasionally been called upon to participate in the evaluation of changes made in work groups in industry, in which the experimental model may be used, and in public health, where it often is not. The method is not completely alien however, even to the field anthropologist, who in attempting to measure the effects of culture change will compare groups in various stages of change and acculturation within and among societies. And the cross-cultural method by which cultural practices are compared among a series of cultures is of course a fundamental anthropological approach.

In attempting to set up control groups in the hospital community the anthropologist must first of all face the existence of medical ethics. From whom does one decide to withhold a certain type of treatment and to whom does one decide to administer it? Is it ethical to randomize the hospital population so that the sample can be selected without bias? Many attempts to randomize inevitably

founder, even if they are permitted by the administration, when the researcher finds that the patients he has chosen may decide not to co-operate, or when their physician may feel that a particular treatment is not to be prescribed for a patient. Some psychiatrists prefer not to deal with patients on a random basis since sooner or later the fact of withholding or administering treatment to patients who are deemed not ready for such action has to be faced.

But suppose, instead of randomization, it is decided to select out a sample on the basis of certain preconceived selective criteria? Then there is some likelihood that objections will be raised because of possible invidious comparisons. With their tremendous, and quite understandable, emphasis on individualization of therapy, practitioners prefer to have the giving or withholding of services performed in accordance with the patient's needs, and nothing else.*

Occasionally the ethic of equal availability of treatment has been breached, and experiments have been set up on fairly rigorous models. Thus one project has been set up which uses control and experimental groups in a state hospital, having selected them randomly according to certain qualifying criteria from among chronically ill schizophrenic patients. Two experimental variables were employed: the presumably more therapeutic milieu of the writer's hospital and a special tranquilizing drug prescription. One group at the state hospital was left completely alone. Another group at the state hospital received the drugs. A third group entered the writer's hospital, and nothing more was done except to subject its members to the usual routine of social therapy and psychotherapy. A fourth group received the same treatment plus the drugs, after transfer to the writer's hospital.

It is of interest to report that in the writer's hospital these research subjects were often known as "project patients," and while in some cases they did prove to be therapeutic challenges for many of the staff, among the physicians such a patient was not referred to as "my" patient in the same possessive way as a patient who was regularly admitted to the hospital. On the other hand when the project with which the writer was affiliated attempted

*Meyer, Henry J., and Borgatta, Edgar F.: An Experiment in Mental Patient Rehabilitation. Russell Sage Foundation. New York. 1959. See especially comment by administrator in preface, pp. 4, 5.

to select out a group of patients and call them "rehab. patients," there was a good deal of staff opposition, on grounds that the patient really belonged to an individual doctor, rather than the project staff. In general, one might suggest that in the large "custodial" state hospitals, controlled research on patients may be expedited by the facts that the prognosis for most back-ward patients is "poor" and that there is such a shortage of staff that any attention shown the patient, even if primarily for research purposes, may be considered beneficial.

Alternative to randomization is the *matching* of individuals in experimental and control groups. It is the writer's opinion that unless individual, rather than group, variables are matched, there are not truly matched groups. If the average measures of groups are used, it seems to the writer that the chances are too great that such central tendency measures cover up what may often be extreme individual differences. Thus, if, as so often seems to happen in reports in the literature, two groups are called matched because both have the same *average* age, socio-economic status, education and so on, the researcher is deceiving himself if he proceeds on the assumption that one group can be the control of the other. The groups may be worth comparing with each other, since, as groups, they *seem* to be alike, but it would be dangerous to make predictions of individual behavior based upon differences or correlations between such groups.

Suppose, however, that it has become possible to overcome all ethical and therapeutic considerations and carefully match two groups. It is not easy to insist that staff members withhold services. Suppose one wishes to study the effects of attention of ward personnel to patients. Successful insistence that only patients so earmarked are to be given or not given attention from ward staff members is unlikely. Almost inevitably forces that attract or repel individuals on a ward will continue to exert their influence. Observation in the natural ward setting, without disrupting the usual flow of activity, may tell the observer more about the effects of attention—by watching what happens in the routine ward situation—than artificially created groups can do. In a milieu devoted to changing the ways of human beings, often in a very thorough and rigorous fashion, as occurs in the instance of the therapeutically-oriented hospital, attempts to control services with respect to specific patients are more easily legislated than executed.

On the writer's project, however, it was attempted to meet the need for comparison or control groups in a manner that can be illustrated by the example of the research done on the hospital work program. This is the program by which patients are placed in varying types of work under the supervision of regular hospital employees, with the objective of providing for them socially useful tasks not often found in craft-oriented occupational therapy. This seems consonant with the cultural values of the society-at-large and is held (as an ideal) to be therapeutic in its consequences for the patient. Each patient who took a job on the work program was interviewed about vocational history and experience. A consecutive series of all discharges was taken, and separated into two groups, those who were placed on the work program and those who were not. As he was about to be discharged the patient was interviewed again, by a different person than the job-placement interviewer—this time with a view of finding out in which work program activities he participated, if any, and what his vocational plans were upon leaving the hospital. He was also asked to rate himself with respect to three factors: his performance in the hospital job, his satisfaction with the work, and what he felt his supervisor thought of his performance. These ratings were marked on precoded scales, two ratings being taken for each scale, one for the beginning point of the work and one for the end point. This afforded the researchers a measure of change in the patient during the period of hospital work.

Simultaneously, but independently, the patient's supervisor was asked to rate the patient's performance, his own degree of satisfaction with the patient's performance, and his estimate of the patient's satisfaction. These ratings were also marked for the beginning and end points. Later the two sets of ratings were compared, and their degree of agreement afforded some measure of validity, as well as of the extent of concordance existing between hospital-employer and patient-employee.

The patients who had been on the work program could then be compared on at least two dimensions with the patients who had not been: (1) the number and kinds of hospital activities in which they participated; (2) their vocational plans, to see whether working in the hospital had any influence on what sort of work the patient planned for the future. The two groups could also

be compared along other variables, for example, diagnosis, length of hospitalization, etc.

Finally, there could be comparison of the patient's performance on the hospital work program with his previous work record and with his future plans, to see what relationships, if any, existed. The patients, thus, could be measured against a series of *"built-in" controls,* using both their own prehospital performance and other patients as controls, or, more properly, the writer thinks, as comparison groups. Originally, it had been hoped to follow a number of these patients into the community to see how they performed at some period after discharge, but lack of funds and additional personnel, as well as pressures of time, made this very desirable objective unattainable at the time. The writer is aware that in this kind of research the follow-up is the final "pay-off," but such a study could not be undertaken in this case.

Use of the patient's past performance as his own base line in attempting to evaluate his rehabilitation is thus done partly out of necessity and partly because of the philosophy that rehabilitation can best be measured, not against a hypothetical norm in the mind of the rehabilitator (a norm which is compounded largely of his personal set of values) but against the patient's own prehospital career. It is possible that the often pessimistic views of results of attempts to rehabilitate psychiatric patients stem, not so much from any absolute measure of the patient's rehabilitative performance, vocationally and interpersonally, but from unrealistic comparisons of his performance with those of persons who have never been ill.

This research has raised some additional questions of an order which are going to be almost impossible to answer. Thus, it is a fact that, in the writer's hospital, being on the work program is voluntary, even though at times it will be strongly suggested by a doctor, a nurse or the industrial therapist. Therefore, there is a decided element of self-selection in the patients who participate in the program. While the interviews attempt to explore this factor, it is not one that can be answered by the use of control or comparison groups, except indirectly by comparing the sociological and psychological characteristics of participators and nonparticipators. This is a further illustration, not only of the difficulty of setting up control groups in an ongoing action situation,

but of the infeasibility of endeavoring to answer certain basic questions through the use of such groups.

Research Perspectives and Service Perspectives

There are crucial differences in philosophy in the individuals who engage in interprofessional research in the hospital organization, particularly when some of them are service-oriented while others are research-oriented. The goal of the service professional is to try to make things work and to maintain a steady enthusiasm about the outcome of his work. The goal of the researcher is to find answers to questions, but not to change directly what he is studying. The sanguine view which the service person must maintain inevitably drives him to minimize failures and maximize successes. The objective view of the researcher is to discover why and how things work; and it becomes as important to study failures as to study successes: Learning where and why a process breaks down teaches a great deal about its dynamics. Therefore the researcher will want to study failure or success in the operations of the hospital as he finds it, and will strive to report both types of outcome. That he spends a large amount of time studying failures is at times dismaying to the service person, who may feel this detracts from the successes, and to the administrator, who may feel the reporting of failures tends to cast his organization in an unhappy light. Both service and administrative professionals tend to feel that failures are best swept aside as unfortunate experiences and that the really effective teacher of process is success. This feeling in turn sometimes may lead to subtle demands that the researcher follow their approach and file away the failures while he emphasizes the successes. The perspective of each professional is understandable in the light of his goals, but each side has a difficult time understanding, or sympathizing with, the view of the other.

Differences in views of members of the interprofessional team extend beyond their philosophical differences. The clinician and administrator will tend to identify with the hospital very strongly. If they approve of the hospital and feel comfortable in it, they will become partisans of its practices and defenders of its fortunes. If they disapprove and feel uncomfortable in it, they will look with a jaundiced eye on most of its practices and policies, and

assume at times an air of martyrdom, as they feel circumstances compel them to suffer unjustly in the organization.

Being human, the anthropologist is also likely to identify ultimately with the hospital in one way or the other. But it is part of his method to strive to see the hospital in cross-institutional perspective, to see it as a particular kind of subsystem functioning within a particular kind of larger society, and to reserve judgment concerning its practices and policies. As a human being, he may approve or disapprove of them quite strongly; as a scientist he constantly attempts to set aside his personal judgments, indeed to delay making them as long as possible, until all the data are in. Even then he will attempt not to make value judgments about the organization's "goodness" or "badness" but only judgments as to whether its operations are functional or dysfunctional with regard to specific practices and policies vis-a-vis organizational goals.

Insofar as the anthropologist may be connected in the minds of service persons with the administration of the hospital, he may be seen in a positive or negative light. If the service people themselves look with favor upon the hospital administration, they will much more readily accept the anthropologist than if they look upon it with disfavor. If they favor the administration, they are likely to be his best informants and the ones most willing to cooperate with him in obtaining data. If they do not favor the hospital administration they will attempt, just as they do with practices and policies of the organization itself, to resist his attempts to collaborate with them, and to gain information from them; and if resistance fails, they may, in subtle ways, undercut his efforts.

Nevertheless, the anthropologist, particularly in an interdisciplinary project, must work with all individuals in the organization whether they approve of him or he of them. They must collaborate, from the working out of a research design to the final publication of results. And they often will be hard put to integrate their efforts, because of wide divergence of philosophy and approach.

A frequent attitude toward the anthropologist, and toward other social scientists, is, "We shall accept you and use your services as long as your findings are immediately useful to us." The anthropologist knows that he can be most useful by doing the things

he knows best. He feels that eventually his findings may be of some use to the hospital. But this is not easily demonstrated. His employers may really be convinced that he will be useful to them; they may even be "oversold" on his potential value to them, in which case their expectations are unrealistically high. Or, they may feel curious about what the anthropologist can do, but be generally skeptical of his ability to do anything which may prove to be therapeutically applicable. In either case there will be some attempt to make over the anthropologist in the image of the clinician. There will be a wish that his findings be cast in their language; they may say, with a heavy sprinkling of their own idiom, that the anthropologist uses jargon when he ought to be "talking English." If the findings are cast in the language of social science rather than of clinical psychiatry, many clinicans feel there is little point to them, since there is no chance they will really understand—and so do not try to understand—them. But should the anthropologist relinquish his professional lexicon and concepts for those of the psychiatrist, he will be operating on unfamiliar theoretical ground, thereby minimizing his effectiveness to himself and to his clients.

It cannot be stressed too strongly that the anthropologist needs to be as useful to himself when his research field is the mental hospital as he may be to the people who employ him. He must feel that what he is doing is anthropologically sound and competent "clinical anthropology," to use Caudill's term. But he can hardly maintain his sense of personal and professional integrity if he succumbs to blandishments, however subtly expressed, and yields to the pressure to "do things our way." Assuredly he needs to be accepted by the other professionals with whom he works, else he shall hardly be able to perform efficaciously. But he must resist the lure of identifying with them and with their professional objectives, methods and language. To be accepted is not the same as to be pleasing. The anthropologist, working in this interprofessional subculture, must be able to maintain his personal and professional identity. The standards which he sets for his research must be those of his own discipline, and the hospital must learn to accept these standards, just as at present it accepts those of medicine, clinical psychiatry, psychiatric casework, clinical psychology, nursing, and so on.

There are many other problems that one might discuss that bear on performing anthropological and other behavioral research in the hospital organization, but space does not permit their review here. In conclusion, it might be said that the anthropologist must learn to live in the mental hospital community, as surely as he learns to live in the community of an exotic society. He must learn to see the mental hospital ways without bias and with minimal effects from his own perceptual screen, which has been conditioned by his own culture and professional subculture. He must operate in co-operation with the other members of the professional team, but at the same time maintain his own autonomy and professional integrity and identity. He must constantly attempt to learn the viewpoints of the other members of the team and they in turn must come to know his. *But even before this point of mutual understanding and recognition is achieved, each must above all respect the viewpoints and techniques of the other.* In such an atmosphere, behavioral research can be maximally effective, and studies of the hospital organization will enrich anthropology and the other behavioral sciences as well as the practice and theory of hospital psychiatry.*

*The question may arise in the reader's mind as to what, precisely, is the unique contribution that the anthropologist may make to the study of mental illness and its treatment. The author has assumed that in part this question is answered by implication of much of the material in this paper. Insofar as they use the tools of the anthropologist, other social scientists may make a similar contribution, but the anthropologist is equipped by training, field experience, and usually predisposition. A crucial basis of the anthropological method is resident observation in the community under study, whether it is a small island society in the Pacific, a neighborhood in an urban Western city, or the psychiatric hospital considered as a small society, as Caudill (See footnote p. 743) has aptly phrased it. The anthropologist considers that the cultural and social systems which he examines receive their integration from the functional interdependence of their parts, and that their natures are determined by the nature of their parts. He looks at the hospital organization in this light, and studies its processes as part of the culture of the hospital and of the culture of the larger society of which it is an institution. He is sensitized to the interrelations of values held by staff and patients with other aspects of the hospital's social structure, and in particular the process involving its major institutional goals: treatment and rehabilitation. He may also use the tools of the sociologist and psychologist, or indeed any other science which can augment his work; but, for him, these are always adjuncts to the anthropological method.

In addition to Caudill, who is an anthropologist, a study has recently appeared by two sociologists using the approach of the anthropologist: H. Warren Dunham and S. Kirson Weinberg, *The Culture of the State Mental Hospital.* (Wayne State University Press. Detroit. 1960.)

SUMMARY

This paper has attempted to deal briefly with the anthropologist's role as researcher into the action program of a small mental hospital, and to discuss some of the problems encountered. An anthropological view of the mental hospital community is presented, with emphasis on its structure as a professional community and its interprofessional competition for the patient. The basic anthropological technique, participant observation, is discussed, and some analogies with the clinical method are pointed out. The clinician's view of the anthropologist's data, while derived with a somewhat similar method, is shown to contain many reservations. At times the hospital attempts to use existing service personnel as research personnel also, as a way of upgrading them and establishing closer links with the research team, but some unexpected consequences of this use are shown. Problems of doing controlled research in the medical setting are discussed, and ways of dealing with the problem in an action research program are illustrated.

Finally, differences between the orientation of research personnel and service personnel are described. The discussion concludes with the strong suggestion that the anthropologist, or other behavioral scientist working in such a setting, maintain his own personal and professional identity, and that research, service, and administrative professionals maintain respect for mutual techniques and points of view.

Graduate School of Public Health
University of Pittsburgh
Pittsburgh 13, Pa.

THE AGITATED DEPRESSION*

BY D. A. SCHWARTZ, M.D.

Introduction

This paper represents an attempt to propose a dynamic hypothesis to explain the form and genesis of agitated depression. It should be stated at the outset that the agitated depression will be broadly considered in this presentation. The term will be used to embrace all depressive illnesses prominently characterized by overt anxiety, motor agitation, restlessness and increased pressure of speech with a stereotyped and repetitive content.

No attempt will be made to separate psychotic from neurotic agitated depressions. Those occurring in the involutional period will be included with those occurring earlier and later. Those occurring in the presence of organic brain disease will be included with the others. This broad use of the concept of agitated depression is intended to suggest that the dynamics of the illness are essentially the same in any of these cases.

It is further suggested that the correspondence between the descriptive aspects of the illness and the dynamic factors responsible for its occurrence is a very close one. This fact in itself is of striking interest, since such a correspondence between descriptive and dynamic factors is far from being the rule in psychiatry.

Scope of This Paper

The concepts of "depression" and of "agitation" are of two different classifications. "Depression" implies a constellation of intrapersonal experiences and feelings: sadness, lack of interest in external events, discouragement or hopelessness, a sense of powerlessness, and physiological disturbances (for example, alterations of gastro-intestinal motility, vasomotor changes, decreased salivation and others). These are mostly inferential things. "Agitation," on the other hand, refers to certain kinds of behavior which are observable but which are not directly related to internal experience.

*This paper was originally presented in the general psychiatry section of the annual meeting of the Southern California Psychiatric Society in Coronado, California, October 23, 1960. The author is indebted to Dr. Seymour Pollock and other discussants who pointed out certain areas of unclarity in it. An attempt has been made to correct these. However, the author accepts full responsibility for the formulations as offered.

This is not to imply that inner experience and feeling *cannot* be inferred from the existence of agitation. It implies only that they have not yet been described. It appears reasonable to raise the question: What is the significance of the agitation which occurs in some depressive illnesses?

This paper is intended precisely to raise that question, and to attempt to answer it. Specifically, a hypothesis will be offered to explain agitation in terms of: (1) the premorbid personalities of the patients exhibiting it; and (2) the nature of the stress which precipitates it.

Descriptive Aspects

Agitated depressions, whether psychotic or not, whether associated with organic brain damage or not, occurring at whatever age, contain certain clear-cut symptoms. Some are more prominent in one patient than others, and not all patients show all symptoms in unmistakable clarity. Still, the constellation of these core symptoms is usually clearly enough in evidence so that observers in general agree the patient has an agitated depression.

The patient is grossly and obviously anxious and agitated. By agitation, the writer means a marked increase in repetitive and apparently purposeless movement, both gross and fine. Parallel to the increased motor activity there is usually an increase in verbal activity which contains the same elements of repetitiousness and purposelessness. Speech tends to be ruminative and designed less to communicate thought content than to express the degree of hopelessness and purposelessness of the patient's existence. Prominent in the verbalization of such patients, are ruminative concerns of physical illness and death, feelings of emptiness, unworthiness and poverty, and repetitive pleas for help. The latter are usually linked with similarly repetitive statements as to the uselessness of help or treatment. Where the agitated depression is psychotic in extent, these ruminations tend to be delusional in quality and may even be nihilistic, the patient saying that he does not exist, that nothing exists, that he is rotting away, that he is empty, and so on. The pressure of this agitation, both motor and ideational, is such as to interfere with sleep, and with effective functioning at work or in relationships with people and, in short, with any sort of productive activity which the patient might attempt or want to attempt.

The conventional psychotherapeutic techniques of reassurance, confrontation, interpretation and so on are ineffective with such patients for the most part, even where the depression is not psychotic. Similarly, "ventilation" appears completely useless, since the verbal productions are not truly ventilative at all but simply ruminative. Until recently, medication has seemed almost equally ineffective, though some of the newer anti-depressant medications appear to offer some hope of influencing illnesses of this sort. Electric shock treatment has been, until recently, the treatment of choice for the psychotic agitated depressions; and it has been a frequent treatment for those of nonpsychotic degree also. Desperation has led to the use of lobotomy for patients with psychotic agitated depressions, in cases where no other treatment seemed helpful.

Dynamic Aspects

The frequent occurrence of agitated depressions during the period of sexual involution led many persons in the past to consider them as physiologically caused, by hormonal or other physiological changes characteristic of this period of life. The greater incidence in women, in whom sexual involution is more obviously signaled (by the menopause) than in men, seemed supportive of speculations of this sort. The ineffectiveness of hormonal replacement therapy did not, however, lend much support to this hypothesis; and the total inability of any sort of chemical treatment to influence the illness in a significant way was similarly discouraging to the physiologically oriented.

Dynamic psychiatrists tended to see the concept of involution in a broader context, and to see the agitated depressions of the involutional period as psychologically caused by the waning of powers in general, sexual or other, and by the increasing recognition of approaching age. The attempts to set apart those agitated psychotic depressions which are associated with cerebral arteriosclerosis or other organic brain disease from the rest of the agitated psychotic depressions seem to be made in disregard of the fact that organic brain disease represents very clear-cut evidence of a waning of power; in fact the waning of a power which people value highly. It has been assumed by those seeking to establish a difference that agitated depressions associated with organic brain disease are organically caused, rather than that they may represent a psychological reaction to the functional effects of the

organic brain disease. It has not been recognized, in other words, that they may represent a pathoneurosis. Clinicians have not demonstrated, however, that there is a significant descriptive difference between the agitated depressions associated with organic brain disease and those occurring in the absence of organic brain disease. The only difference is the addition of symptoms and signs of organicity in the former.

It is repeatedly observed that agitated depressions occur predominantly in individuals of a compulsive* personality type. This is so broadly accepted that the existence of a clearly-marked compulsive personality type before the onset of illness is one of the factors considered in making the clinical diagnosis. Nevertheless, little has been written concerning the dynamic significance of this characteristic premorbid personality in patients with agitated depressions. (A significant exception is an article by Barnett et al., which will be referred to later.) Yet the parallel between obsessional thinking and the depressive ruminations of the patient with the agitated depression is striking. Similarly, the agitated behavior has a ritualistic quality. The purposelessness of the depressive ruminations and their noncommunicativeness is another parallel to obsessional thinking. Viewed as divorced from the depressive content, the general form of agitated behavior and agitated speech is obsessional in character except that it is in the sphere of activity, or of doing, rather than in the sphere of thinking.

Suggested Dynamic Hypothesis

The hypothesis to be offered here rests on the characteristic premorbid compulsive personality in the individual who develops an agitated depression. The compulsive character structure is one in which the defense against conflict is by "doing"** (as compared

*The terms "obsessive" (or "obsessional") and "compulsive" are used frequently in this paper. As Rado (*American Handbook of Psychiatry*, Basic Books, New York, 1959; footnote on p. 324) points out, these two words were originally different translations of the same German word used by Freud. Contemporary convention has been to describe obsessive-compulsive *character disorder* as "compulsive" and obsessive-compulsive *neurosis* as "obsessive" or "obsessional" (although there are occasional references to "compulsive neurosis"). The writer has followed the general convention without intending to imply any distinction between the terms, other than the conventional one.

**The term "doing," as it is used in this paper, is meant to imply more than just any action; it is used to refer to successful performance of tasks, often perfectionistically done; it implies accomplishment, achievement, the need to do the best. It might be better called "outdoing."

to the paranoid character in which the defense against conflict is through "thinking," the impulsive character in which the defense is through "acting out," and the schizoid character in which the defense is through "fantasying"). These characteristic defenses (in the case of the compulsive character, the defense of doing) become the prime mode of dealing with the world in an adaptive fashion, the most adaptive fashion which the patient is capable of using.

The prime threat to an individual with a character disorder is a situation which somehow prevents the employment of the characteristic defensive mode of behavior. Alternative modes of behavior are not well developed, and the personality is not flexible enough to cope with a situation without its major defense. In the case of individuals with certain kinds of impulse disorders, what happens when the freedom to act out is taken away is graphically demonstrated by the Ganser syndrome, so commonly seen in impulsive individuals who are imprisoned. This form of psychotic regression occurs when an individual whose major defensive operation is acting out, is placed in a situation where he cannot act out because of rigid external restrictions, bars, walls, guards.

It is the present hypothesis that the agitated depression represents the regressive phenomenon which is seen when an individual with a compulsive character structure is faced with a situation in which, somehow, the "defense by doing" cannot function. The blocking of the doing-defense may be literal and actual, or may be more primarily symbolic and anticipatory. For example, the occurrence of organic brain disease, with its attendant impairment of intellectual facility, represents an actual and literal impairment of the defense by doing. On the other hand, the involutional period, with its implication of waning powers and the approach of age, represents a more symbolic inactivation of the doing-defense. In women, this symbolism is more clearly evidenced by the cessation of menses and by physiologic changes attendant to hormonal variations during involution. This may have some bearing on the greater incidence of agitated depressions in the involutional period in women, as compared with those seen in men. The writer's clinical impression is that agitated depressions occurring in individuals with organic brain diseases and consequent intellectual impairment, show a more even sex distribution, which would be consistent with his hypothesis.

Why depression? Why should the decompensation of a compulsive character lead particularly to depression? And why to an agitated depression? From one aspect, a depressive reaction is not an unlikely one in the face of a decompensation from a compulsive character structure, in the light of the psychodynamics of obsessive-compulsive neurosis and of depression. These two sorts of emotional disturbance are related to a similar period in psychosexual development; and the most immediate regression from that period of development in which the obsessional conflict first occurs is to the immediately preceding period, during which the conflicts characteristic of depression find their origin.* From another point of view, the core of depression is the inability to do. Perhaps this has been most clearly expounded by Bibring[1] who views depression from an ego-psychological point of view. He points out that the core feeling in depression appears to be one of a powerlessness of the ego to undo a loss. From this point of view again, a conflict situation or an occurrence in which the doing-defense is made inoperative might be logically expected to lead to a neurotic reaction or a psychotic reaction, in which the core of the emotional disturbance *is* one of inability to do.

This is not meant to suggest that the agitated depression is the only form which decompensation from a compulsive character structure can take. The author means only that it tends to take this form when the stress leading to decompensation is an event which constitutes or represents loss of part of the self, a loss of something conceived of as an essential for the doing-defense. Compulsive individuals faced with other sorts of stress may regress in other ways.

So far as agitation is concerned, it may be viewed in one sense as an unsuccessful attempt at doing. In other words, agitation represents motor behavior and ideation being utilized, but in the absence of goal direction or successful function. It may well be conceived of as the operation of the verbal and motor manifestations of doing or functioning, in the absence of the ego's ability to channel this behavior adaptively. As was indicated earlier in this paper, agitation on a motor or verbal level shares certain

*One might make an even wider flight of fancy by pointing out that the infant's progression from the late oral period of life to the anal period is paralleled by progression from less purposeful to more purposeful motility. This particular phase of development is characterized by the child's struggle to master his environment by doing.

characteristics of obsessional thinking and represents a state somewhat akin to an obsessional neurosis. In the agitated depression, this is complicated by feelings of powerlessness, guilt, and incapacity or emptiness.

The quality of agitation is (speculatively) presented here as resting on two pre-conditions: (1) the existence of a compulsive character structure; and (2) some loss of self which impairs the doing defense. It is quite conceivable that a depression may occur in the involutional period: (1) in some other sort of person; or (2) in response to some other kind of stress. This provides the explanation for the depressions occurring without agitation in the involutional period. At present these are rationally unclassifiable.

Some of the other symptoms so characteristic of agitated depression can be seen dynamically to fit readily into the suggested hypothesis. The hypochondriacal traits, the preoccupation with death, and the anxiety may be conceived of with some justification as related to impairment of function, inability to do (which may be symbolized as death). Delusions of poverty may be understandable in terms of the meaning of money to the compulsive individual. From a somewhat different point of view, however, poverty represents a lack of the means to do certain things and similarly is symbolic of the loss of functioning defense. Though it may be stretching a point and though it is certainly speculative, the nihilistic delusions may be conceived of similarly as symbolic representations of the decompensation of the compulsive character structure: "If the ability to do is gone, then there is nothing for me."

Depressive reactions in general are felt to occur in response to the loss of some external object or some external source of narcissistic or other supplies which the patient wants and needs. Agitated depressions, though some of them can be fitted into such situations of external loss, seem most often to be lacking in clearly demonstrable factors of this sort. In agitated depressions, the loss which seems to represent the stress may be conceived of as a loss of self rather than as a loss of something external. This seems fairly straightforward in those cases in which the stress represents sexual involution or anticipation of age. It seems reasonably clear-cut in those patients in whom organic brain damage with consequent intellectual deficit has been the stress. In other

cases, such as one recently seen by the author (see Case 6, to follow), in which financial loss represented the stress for the reaction, it seems less clear-cut. However, in the patient in question, it seemed as if the money represented less an external object to her than an extension of herself, something which provided her with the ability to do that which she wanted to do. The loss of the money represented to her a loss of one of her capacities in life, rather than a loss of supplies or of a symbol of external love.

Following the loss of significant persons, the classical form of depressive reaction is that of a retarded depression, something paralleling the mourning experience. The difference between normal mourning and depressive reactions has to do with the patient's internal dynamics. If the loss of a person in the present revives internal neurotic conflict concerning an introjected object, it leads to neurotic or psychotic retarded depression, rather than to normal mourning. Agitated depressions do not seem to be manifested in situations where the loss is clearly external, even where the individual suffering the depressive reaction is one with a compulsive character structure.

It may readily be conceived why some literal or symbolic loss of self or of one's ability would be a specific threat to the compulsive character, whereas it might represent a considerably lesser threat to some other sort of individual. One's own structural or functional integrity is the basis for the doing-defense. Sexual loss, intellectual loss, waning powers of all sorts, represent losses of the individual's ability to do and are therefore a primary threat to the individual whose major or only way of dealing with life is *by* doing. Such a person, however, may compensate reasonably well for external loss, since the external loss is not so direct a threat to the individual's ability to adapt himself or to defend against the feeling. Loss of self, specifically loss of ability or functioning capacity is a much more severe threat because it impairs the entire defensive structure. It is not a situation to be coped with; it is something which impairs the coping itself.

The distinctions between the two kinds of loss are not, in clinical practice, so clearly defined and separated from each other as may be implied here. Similarly, character structure is not an "either-or" proposition in real life. If the present formulation seems to imply that such a distinct differentiation can be made,

it is unintentional. For purposes of discussion, it is often helpful to make verbal distinctions which are not clear-cut in actuality. People in general have varying degrees of compulsiveness (from none to much) in their character structure, and any loss is more or less a loss of self. From a clinical standpoint, what the writer intends to suggest here is that a depressive reaction will be an agitated one in proportion to the extent to which the stress represents a loss of the capacity to do, and to the extent that the patient's character structure is a compulsive one.

The inability of psychological techniques to influence the thought content in agitated depressions, even nonpsychotic ones, is possibly best understandable in terms of the obsessional quality of the thought content. What the patient says does not represent an attempt at communication of thought content. Therefore, attempting to deal verbally with the patient's verbal productions is not a real communication to him, any more than would be a direct attempt to talk an individual out of an obsessional thought in cases of obsessional neurosis. Other than for electric shock treatment and some of the newer anti-depressant drugs, those approaches which have seemed to offer some benefit to agitated depressions are approaches which bolster the doing-defense. Henderson and Gillespie[2] reflect this fact in their comment, "If we are able to get such patients to work, even in a mechanical way, the outlook is so much the better."

It has long been known in psychiatric hospitals that depressed patients do well when given complicated, difficult and dirty tasks to do. The writer's own experience has borne this out in cases of agitated depression. He has found that patients with agitated depressions seemed to respond fairly uniformly in a positive way to being given extra work and tasks to do. The performance of these tasks appears to offer a situation into which the adaptive, doing-defense can enter in some successful sort of way. Around the successful performance of extra-detailed and tedious tasks given to such patients, there appears to be a lessening of the feelings of depression, a lessening of the purposeless agitation and some beginning recognition of capacity for coping with problems.

Instinctual impulses and the role of the super-ego have not been mentioned in this formulation. This omission is not intended to imply that they are unimportant. Obviously, they are of crucial importance in the development of personality structure. Con-

sequently, they are of crucial importance in decompensation. They are excluded from the formulation simply because they do not enter *directly* into the *process* of decompensation. Perhaps this is simply a more complicated way of saying: Ego psychology is not a negation of id psychology; it is simply a different point of view from which certain personality dynamics may be viewed.

Case Material

The following cases are illustrative of agitated depressions seen by the author. All were hospitalized.* The parenthetical comments indicate the severity of the depression, whether it was psychotic or not, and the age period of onset: involutional, post-involutional or pre-involutional.

Case 1

(Moderate degree of depression, not psychotic, onset in the involutional period.)

A 38-year-old divorced woman had an onset of depression five months before hospital admission. This immediately followed two incidents which occurred at about the same time. One was the abrupt cessation of menses. The second was a fall the patient suffered at work, with consequent head injury and unconsciousness. The diagnosis was concussion. Following the injury, electro-encephalographic examination was reported as showing a severely abnormal tracing with diffuse paroxysmal activity, suggestive of a convulsive disorder. The hospital record does not indicate much concerning the details of the premorbid personality. The patient is described as a passive person who was never able to express anger and who responded to emotional traumata by feeling guilty and hurt, without ability to recognize her hostile feelings. One of her major ways of coping with interpersonal relationships was to try to make herself indispensable to people.

The symptoms of her illness included anxiety, irritability, distractability, restlessness and sleeplessness, feelings of depression and a degree of heightened psychomotor activity and tension described as "agitation." The medical record reads in part that the patient tried to check her anxiety by taking on "numerous compulsive and obsessive rituals" which she described as "little tests of memory." These included remembering insignificant names, dates and occurrences, to test how well her mind was functioning. The tests became more and more difficult and involved, and she did less well on them, which led to increased emotional disturbance.

*Case 2—Medical Service, University of California Medical Center, Los Angeles; Case 5—Langley Porter Neuropsychiatric Institute, San Francisco; all others—psychiatric service, University of California Medical Center, Los Angeles.

This patient also had congenital cataracts which were felt to contribute to her emotional upset. The patient was hospitalized in the period before the newer anti-depressant drugs, and was not felt to be severely enough depressed to justify the use of electric shock treatments. She was treated with psychotherapy and with chlorpromazine, 200 mg., daily. She responded fairly well to this regime, with improvement of a moderate degree in her depression. While hospitalized she had surgery on her eyes. Each surgical procedure, with the necessity of being blindfolded postoperatively, led to an exacerbation of all the symptoms of agitated depression. Each time, the symptoms subsided, and the patient was discharged as improved.

Case 2

(Moderately severe degree of depression, not psychotic, onset in the involutional period.)

The patient in Case 2, a 50-year-old married woman, was seen recently for psychiatric consultation. She is described as having been scrupulous, perfectionistic and compulsively neat before her illness. Five years before hospitalization, at the midpoint of a two-year-menopause, the patient had had the onset of symptoms of depression, "nervousness," sleeplessness and restlessness, rumination about her incapacity, inadequacy and loss of memory, and feelings of hopelessness. These were severe enough to cause a loss of her previous compulsive qualities. She became careless in her care of the house and herself and not able to function to any degree. She received 22 electric shock treatments early in her illness but did not feel that these helped. She indicated that talking with psychiatrists over the course of the five years of her illness had made her feel worse rather than better, since it led to increased rumination about her past life and current symptoms.

When hospitalized on a couple of occasions in psychiatric hospitals, she had marked improvement in her symptoms. This was attributed by her physicians to her being around people, since the patient was married to a rancher and lived in a degree of relative interpersonal isolation. In discussing her psychiatric hospital experiences, the patient indicated that she had spent more time listening to other people's troubles than talking about her own, that she enjoyed doing this and was a better listener than talker. She indicated also that the other patients would tell her it helped them to talk to her. (It is interesting to note how the patient's spontaneous comments in this area indicate clearly the nature of the hospital experience. What was important to her about being in the hospital and around other people was not that there were others to support her but that the other patients gave her an opportunity to feel of use and feel important. Apparently, this led to some reversal of her own feelings of inadequacy and helplessness. Imipramine was recommended for this patient, but no follow-

up report is available, as the patient was seen only two weeks before the time of writing.

Case 3

(Severe degree of depression, psychotic, onset in the involutional period.)

This patient was a 47-year-old single woman described as having always been hard working, responsible, extra-conscientious and moralistic. She had been going out with a "boyfriend" for the past 20 years but had never married because she felt responsible for taking care of her now aged and physically ill mother. One year before hospitalization, her menses ceased, and she began at this time to review her life (and particularly the 20 years she had spent in caring for her mother). This "review" is described as having had a ruminative quality. The patient had always worked and had been working for one firm for many years.

Around the time of her "review," automation had led to certain changes in the operation of the firm and the patient became fearful that she might lose her job. She wondered what she would do if this happened and feared that her own inadequacy would cause the loss of the job. This state of concern progressed to one of agitation, anorexia and weight loss, sleeplessness, feelings of depression and obsessive ruminations about her inadequacies. When she was seen at the hospital, she was described as restless, tearful, wringing her hands, having slow speech of a repetitious quality, revolving around guilt and persecution. She seemed suspicious of other people and anticipated physical attack by doctors and orderlies in the hospital, in retribution for "how terrible" she had been. Her feelings in this area had a delusional quality, though the delusions were not systematized. There were no hallucinations.

The psychological evaluation revealed some perceptual and spatial deficiencies, suggesting slight organic impairment in addition to her depression. The patient was treated with imipramine, 200 mg. daily, with psychotherapy directed toward returning her to functioning and encouraging her assertive and aggressive feelings, which had always been repressed.

She had a fairly complete remission in a two-month hospitalization period reverting to her premorbid compulsive personality structure. A follow-up a year and a half later—after some out-patient treatment aimed at helping her to cope with the premorbid personality problem itself—indicated continuation of the good result and even improvement in the characterological problem. (It was around discussions concerning the treatment of this patient that the hypothesis offered in this paper was developed, since her physician was seeing the writer at the time in consultation. The psychotherapeutic and management approach to the treatment of this patient was in consonance with the hypothesis offered here.)

Case 4

(Moderately severe degree of depression, not psychotic, onset after the involutional period.)

The Case 4 patient was a 64-year-old married woman whose onset of illness was three to six months before hospitalization. She was described by herself and others as having been conscientious, hard-working, very neat, "fussy" and "particular," and was described as "compulsive" by the physician who saw her in the hospital. Six years prior to admission, the patient had developed numbness and a sense of "pressure" in her left thumb, associated with pain in her left arm. Her incapacity from these symptoms was so severe that she had to leave her job as a school nurse. Since that time she had become somewhat more worrisome, fretful and preoccupied with her health. She was able, however, to work one day a week as department store nurse. Three to six months before hospitalization she had had an onset of feelings of depression, accompanied by agitation, restlessness, anorexia and weight loss. At this same time, the patient had symptoms of dizziness which were diagnosed by her family physician as Menière's disease. (Later evaluation suggested this may have represented a minor cerebrovascular accident.) When she was seen in the hospital, there was evidence of memory deficit and confusion. Psychological evaluation revealed a clear-cut organic deficit in addition to the depressive illness.

The patient was treated with imipramine, 200 mg. daily, and with psychotherapy. Her depression and agitation cleared fairly promptly under this regime. The organic deficit, however, persisted. The final diagnosis was of chronic brain syndrome associated with cerebral arteriosclerosis, with a neurotic depressive reaction which was described as "an agitated depression." Following remission of the agitated depression, she was discharged to the out-patient clinic and was followed there for six months. She was able to return to work for one day a week, and medication was withdrawn gradually without recurrence of the illness.

Case 5

(Severe degree of depression, not psychotic, onset after the involutional period.)

A 61-year-old divorced woman was seen by the author during his psychiatric residency. She was described as always having been hard-working, compulsively neat and overprotective toward her children. She had kept a home for them until their marriages eight and five years prior to her hospitalization. Shortly after the marriage of her son, five years before, this patient had been evicted from her apartment, and at this time she moved in with her married daughter. Because of symptoms of palpitation and flushing, she saw her family physician who told her she had hypertension and was to limit her activities. The patient attempted to do this

but found it difficult in the light of her rather compulsive character structure.

Three years before she was seen in the hospital, she had a gastric resection for a bleeding peptic ulcer. Following this, she developed a depressive illness characterized by restlessness, anxiety, sleeplessness, anorexia and weight loss. She was treated by electric shock with only temporary improvement. Hospitalization at a state hospital led to a recommendation for lobotomy. She was transferred, with this recommendation, to the hospital in which she was seen by the author. Review at that time led to a decision to attempt to treat her by psychotherapy. At the time, she was restless, anxious, pacing the floor, wringing her hands, writhing about in her chair. She was unable to sit still and her arms and legs were covered with bruises caused by inadvertent striking against the furniture. She had a constant anxious and piteous expression on her face. She spoke repetitiously of her somatic symptoms, of being a burden, and of being useless and hopeless. When she was told not to talk about these matters, she became more agitated, and when permitted to discuss them, became less so. (This seemed to be an interesting illustration of how the limitation of the obsessional mechanism led to increased agitation.)

Psychotherapy over a period of three months seemed to be of no help at all, and the patient's mental status at the end of that time was almost exactly what it had been at the beginning. The departure of the author from the service where the patient was, and her acquisition of a new therapist led to a decision to abandon what seemed to be an abortive psychotherapeutic attempt, and her condition was treated with EST, which led to a good remission of her illness and a return to her premorbid personality. She was treated by maintenance electric shock and remained entirely well over the six-month period during which she could be followed. No follow-up is available beyond this time.

Case 6

(Severe degree of depression, not psychotic, onset after the involutional period.)

Case 6 was that of a 57-year-old married woman described as having an obsessive-compulsive character structure and being very religious and guilt-ridden about any deviation from strict morality. She had a history of depressive illness twice in the past, once at 36 when her daughter was born, and once at 45 when her husband made an unwise investment. The nature of these depressions, their duration, and response to treatment is not known. At 55, two years before admission to the hospital where she was seen, her husband invested all of their savings in a business venture whose soundness the patient doubted. The patient feared that the money would be lost and that she was doomed to an old age of poverty and

helplessness. She had counted on the money, which had an extreme degree of importance to her, to be her security against helplessness and impoverishment in her later years. Immediately following this incident she developed severe anxiety, hyperactivity, and shaking of her head, as well as of her whole body at times. This shaking varied in severity and at one time was said to be so bad as to require physical restraint.

The patient was described at the hospital as restless and in constant movement. She shook her head constantly. She appeared sad and dejected, and she tended to answer questions that had emotional content with stereotyped replies, such as, "Well, I can't quite remember," or "I just don't know the answer to that." She asked continually if she would get better, and this same stereotyped question was asked no matter how much reassurance or what kind of response it had previously evoked. The patient had received 16 electric shock treatments early in her illness but this had provided only minimal benefit. Psychotherapy was felt to be useless for her. An attempt was made to treat her with prochlorperazine in doses up to 600 mg. daily. This led to a moderate degree of improvement in her agitation, but to a worsening of her ability to relate to other people. She was removed completely from this medication and then treated with imipramine, 200 mg. daily, later reduced to 150.

In the following four to six weeks, she went into a complete remission, with the only remaining symptom a minimal shaking of her head. Neurological evaluation during her hospitalization had led to some feeling that an extrapyramidal lesion might play a minor role in the symptom of shaking. This was never fully clarified, though the persistence of minimal head-shaking in the face of disappearance of all other symptoms may support that hypothesis.

Case 7

(Severe degree of depression, psychotic, onset after the involutional period.)

In Case 7, the patient was a 58-year-old married woman who is described as having led a puritanical existence during her early life and as having repressed most of her instinctual desires. She married in her thirties, and her adult life was consistent with the hypothesis of a basically compulsive character structure. She had had hypertension for a number of years. Surgical menopause occurred 10 to 12 years before her hospitalization. Two years before she was seen in the hospital, she had seen her internist again in connection with her hypertension and had apparently had some exacerbation of this difficulty. At this time, there was an onset of symptoms of depression, accompanied by talkativeness, constant complaining, tearfulness and repetitive statements about how sick she was. She told of feelings of estrangement, feelings that people "looked different" and peculiar feelings of unreality or depersonalization which she

never was able to describe very clearly. About this same time, it was discovered that she had diabetes mellitus, and she was placed under treatment for this.

In addition to the symptoms noted, the patient complained in the hospital of various somatic symptoms, such as "bubbling from the vagina," the puffing out of her arms and legs (not supported by objective examination), a crawling feeling in her back and a tickling in her head. These were felt by her physician to be delusional. Hallucinations were not prominent, but at the beginning of her hospital experience she heard some voices saying she was going to die. No other hallucinatory content could be elicited.

Physical and laboratory examinations revealed diabetes mellitus, with a blood sugar of over 200 mg. %, and blood pressure of 210/140. Psychiatric and psychological examinations showed evidence of clear-cut organic brain damage, in addition to the depressive illness. The etiology of this organic defect was not clear. The patient had been treated with electric shock, with some transient improvement, 18 months before she was seen in the hospital. It was established that the feelings of estrangement and unreality, and the memory impairment had begun at the onset of her depressive illness, and did not first appear after electric shock treatment. (This point is made explicit, because many cases which have been cited to show that electric shock treatment causes brain damage may well be similar to this one. Such patients may have received electric shock for agitated depressions which had been precipitated by unrecognized minor brain damage in the first place.)

The patient under discussion was seen before the development of the newer anti-depressant drugs. She was in the hospital for evaluation only and was discharged to the care of her private psychiatrist after a six-week study, and with only minimal lessening of the severity of her illness.

Case 8

(Severe degree of depression, not psychotic, onset before the involutional period and in a man.)

The patient was 28 years old, married, and described as having been meticulous, hard-working and a chronic worrier. He was also described as having been the passive son of a stern father. His difficulty began a year and a half to two years prior to hospitalization, with the onset of anxiety, headache, choking and hyperventilation. These symptoms appeared to be related to the death of his father from a cerebral hemorrhage, and to the patient's graduation from a professional school. Two attempts at psychotherapy before his hospitalization had failed. In the hospital, he was anxious, restless, paced the floor, complained of somatic symptoms, begged for, and at times demanded, help, was irritable, depressed and fearful.

Psychotherapy in the hospital setting did not seem to be helpful. Since some of the clinical features he demonstrated closely resembled agitated depression, the patient was treated with a combination of chlorpromazine, up to 1200 mg. a day, and imipramine, up to 300 mg. a day. There was a sudden improvement three weeks after the beginning of medication, and the patient went into virtually complete remission in the two weeks following this. The chlorpromazine was discontinued, over a period of a week, and the imipramine decreased to 75 mg. a day. The patient was discharged to private treatment following this and has not been heard from since.

Only one of the eight cases presented fulfills the strict criteria for the involutional psychotic depression. Only Case 3 is a psychotic illness beginning in the involutional period. Case 7 is a psychotic illness with onset eight to 10 years following surgical menopause. Case 8 had its onset in the twenties. Cases 1, 2, 4, 5 and 6 were not psychotic but otherwise qualitatively like the psychotic agitated depressions. Cases 4 and 7 showed clear organic brain damage. Cases 1, 3 and 6 showed suggestions of organic brain damage of varying sorts. However, the most impressive evidence was in Case 1, where the depression was the mildest of all those reported.

The success of imipramine in Cases 3, 4, 6, and probably 8, is in consonance with the author's clinical impression as to the effectiveness of this drug in agitated depressions.

Case 3 is being prepared for publication by Arnold Mandell, M.D., the patient's physician. Dr. Mandell's case report will detail the psychotherapeutic approach which was based on the hypothesis offered in this paper.

Comment and Summary

An interesting article by Barnett and his associates in 1953[3] dealt with the problem of involutional melancholia. The authors recognized that the significant thing about involutional melancholia was that it was an agitated depression. Moreover, they perceived that the patient with an agitated depression had suffered a loss of something in himself. As to the nature of the something in the self, the present formulation does not follow these authors. They felt that agitatedly depressed patients experience "withdrawal of love from within the personality . . . from the superego." They differentiated such patients from those with reactive depressions, in whom they felt the loss was a loss of love from a current environmental object.

The writer does not believe this is a valid distinction. It is true that the patient with a reactive depression suffers a loss of love from a current environmental object. But if this were all, one would expect not a depressive reaction, but only normal mourning. The additional requirement for the occurrence of a depressive reaction is precisely that the current loss revives a neurotic conflict in relation to introjected objects. In agitated depressions, something different is lost from the self; the something is a part of the ego which is felt to be necessary to maintain the compulsive character structure: the doing-defense.

Barnett and his co-workers accurately recognized that the agitated depression represented the decompensation of an anal (or compulsive) character. They also pointed out that the term "involutional" was misleading, and that the involutional period of life represented only one (and not the only) stress which might lead to decompensation. This present paper differs with them primarily about the point of view from which the decompensation is discussed. Barnett presents it in terms of libido theory, while the writer sees it from an ego-psychological point of view. Underlying this aspectual difference is the writer's feeling that the crucial factor in the genesis of agitated depressions is some specific ego loss, not just lessening of the ego's ability to satisfy superego demands. If the latter were the case, it would be hard to see why every compulsive character does not develop an agitated depression with advancing age. Moreover, one would expect maximal incidence of the agitated depression in older patients, rather than in those at the involutional age.

In brief, then, the agitated depression appears to represent an emotional disturbance characterized by obsessional rumination about powerlessness and inability to do, coupled with verbal and motor behavior of an obsessional and purposeless quality. The reaction occurs in an individual whose entire character structure and way of relating to people and to the environment in general has been through doing, through the compulsive characterological defense of successful function. The stress which acts upon the individual to produce this particular disturbance is one which represents a loss of self in some sense, a loss of something which represents to the patient, or which is literally, an integral part of himself as a doing and functioning person. By implication, then, the treatment (other than specific somatic treatment which is

effective) is that treatment which is directed at re-establishing the doing-defense in any area where it can be re-established, so that the feeling of incapacity and loss of self is contradicted by the actual evidence of successful function.

University of California at Los Angeles
Department of Psychiatry
Los Angeles 24, California

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EDITORIAL COMMENT

ONE-EYED JACKS AND DEUCES WILD

There are passages to recall a crow-caucus, the Mad Tea Party, and an all-night poker game in that fascinating document, *Action for Mental Health.**

THE QUARTERLY is indebted to John H. Cumming, M.D., director of the New York State Department of Mental Hygiene's Mental Health Research Unit, for enlightening comment on the book's proposals to employ clergymen as mental health counselors. *Action for Mental Health* represents the conclusions and recommendations for Congressional action, as finally agreed upon by the Joint Commission on Mental Illness and Mental Health; Dr. Cumming notes that it contains "three different indications for the competency of the clergyman in dealing with those who have emotional problems. First, although untrained for mental health work, he is the most successful of the community mental health workers; second, that he can with relative ease be trained to be competent and third, that he must have intensive clinical training in order to be competent."** Or: The clergyman is already the best community counselor; he needs a little training to be a counselor; he needs a lot of intensive training to be a counselor.

To get down to cases, how long would it take to teach a clergyman to recognize blocking as a sign of serious illness? (And then how long should the clergyman take to send a patient to a doctor?)

Perhaps one should refer to the clergy themselves. The Rev. W. W. Meissner, S.J., reports in this issue on the results of introducing 26 young Roman Catholic priests to a nine-day period of ward visitation and study at St. Elizabeths Hospital, Washington.† At the risk of interpreting what the reader can better consult for himself, it may be said that Father Meissner found that the visitors—initially somewhat favorably disposed toward psychiatry as shown by psychological testing—were inclined generally by

*Action for Mental Health. The Final Report [to Congress] of the Joint Commission on Mental Illness and Health. Basic Books. New York. 1961.

**Cumming, John H.: Chairman's remarks at American Psychiatric Association's Thirteenth Mental Hospital Institute, Panel on Secondary Prevention, Omaha, October 1961. Quoted from personal communication to editor.

†Meissner, W. W.: Psychiatric training for theology students: a report. PSYCHIAT. QUART., 35:4, 720-725, October 1961.

their experiences to still more favorable attitudes, but that the change was not enough to be significant. The young priests were in more general agreement, after their experiences, that parishioners should be referred to psychiatrists when mentally disturbed; but Father Meissner nowhere indicates that they felt themselves competent to diagnose, much less to treat, mental illness. On the contrary, they finished their visit with a somewhat increased feeling that more teaching of the findings of psychiatry was needed in the seminary.

There is no doubt that not entirely dissimilar findings could be reported of clergymen in other dominations. The Joint Commission could have found voluminous discussion of this point in publications addressed particularly to the clergy, ranging from journals to books —none from a responsible source advocating, so far as this QUARTERLY is aware, that theologians undertake serious psychiatric treatment.

To this journal, the Joint Commission's recommendations on counseling suggest dealer's choice by a desperate poker loser, seven-card stud with one-eyed jacks and deuces wild (or scoutmasters, schoolteachers and county farm agents rated as aces and kings—or professional advisers in a medical specialty). The commission's summary of recommendations for who should counsel "in the absence of fully trained psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses" (the aces and face cards?) includes "a host of persons untrained or partially trained in mental health principles and practices," who are "already trying to help and treat the mentally ill in the absence of professional resources," and who "with a moderate amount of training . . . can be fully equipped . . . as mental health counselors." The Joint Commission then names some of these lesser cards in the pack: "clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents [the deuces?] and others . . ." If there are extra cards here—bartenders, barbers, beauticians!—so much the better. According to dealer's rules, just call them counselors, and—with a little training and access to expert advice themselves "as needed"—they will pull in the pots like professionals.

At this point it seems appropriate to ask, "Who called that county agent a counselor?" Inasmuch as the Joint Commission

classes the county agent, with the judge, the public welfare worker and the public health nurse—and without discrimination among them—in the group of people "now trying to help and treat" (and capable of doing so with some training and advice), this is not a rhetorical but a serious question. The Joint Commission also classes as already fully competent counselors "fully trained psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses" without discrimination among them either, insofar as counseling and the supervising of counseling are concerned.

The Joint Commission defines, as persons to be counseled, those "who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate . . ." and defines the counseling process itself as "the detection of beginning signs and symptoms of mental illness and their relief; in other words, the earliest possible treatment." This, in the meaning of the plain English employed, is more than counseling, which is generally restricted to advice in interpersonal and environmental difficulties, not treatment for internal distress. But here is the practice of psychotherapy, which is the practice of medicine. It raises that serious question, which this journal proposes to discuss at length on some future occasion: "Who should practise medicine?"

For the present, it might be remarked that county farm agents, probation officers and clergymen should not—unless they are also qualified in medicine. Nurses and judges and social workers should not. Scoutmasters and teachers should not. Even some of the "fully trained" professionals listed by the Joint Commission are not good counselors for persons with incipient mental disease—a condition which does not call for ordinary counseling and does call for psychotherapy.

In view of the Joint Commission's recommendations, it seems necessary to repeat a most elementary statement here: Not everybody should do psychotherapy. There are many psychiatrists who, though medically qualified, are not good psychotherapists. The rest of the "fully trained" professionals the commission names are not medically qualified at all. Some trained clinical psychologists are doing psychotherapy, as are some social workers. The psychiatric nurse is sometimes considered to practise "ward therapy."

Useful as they are, these procedures are not proper psychotherapy for actual mental disease—or adequate training for it. They are also all ordinarily performed under medical direction. (They all ought to be.) It would not be honest to deny that the nonmedical disciplines have produced competent—and distinguished—psychotherapists: Sachs, Slavson, Reik, Levy, Wallin, and Gertrud Schwing, for instance, in psychoanalysis, treatment of children, and group psychotherapy. But some of these people were trained by Freud himself; all had exceptional aptitude and experience; none was fitted for psychotherapy by the nature of his nonmedical profession; and all were of unusual ability. There were tens of thousands of barber-surgeons and only one Ambroise Paré. To take a psychiatric nurse, psychologist or social worker at random and expect to find a psychotherapist is like drawing a card from a full deck and expecting it to be the joker.

Freud himself is partly to blame for the popular delusion that anybody can do psychotherapy; it is true that he battled to keep psychoanalysis a nonmedical discipline. He never meant, however, to suggest that general psychological training, or social work training, or training in nursing was adequate preparation for psychotherapy. He insisted on rigorous selection and special training of psychotherapists, lay or medical; he held that they would not be laymen in their specialty when they began to practise. And he intended them to deal with the psychoneuroses only, and laid down the rule that the lay analyst should treat only after examination by a physician and only then in co-operation with a physician.* A neurologist himself, Freud did not intend to have nonmedical people diagnose actual mental disorder and then treat it on their own responsibility. Incipient mental disorder may be incipient psychosis, not incipient neurosis; and Freud never intended nonmedical people to do psychotherapy with psychotics; in fact, until Paul Federn demonstrated the contrary, he believed psychotics could not be successfully treated in that way.

If this seems to be a lot of pother and palaver to raise about what ought to be obvious, it should be remarked that the Joint Commission, which one may presume is far more conservative than Freud was, does not seem to regard it as obvious. The proposal to turn Tom, Dick and Harry loose to treat people in the field of psychotherapy-counseling (the operative phrase is "to

*Freud, Sigmund: The Question of Lay Analysis. Norton. New York. 1950.

treat") seems to be made in all seriousness, in spite of the dithering already cited about what the untrained clergyman needs in the way of no, little, or extensive, training before undertaking mental health counseling.

The purport of the whole is plain enough; and in this journal's view is exceedingly ill-considered. The frames of reference of many clergymen, judges, teachers and parole officers are authoritarian, and there are types of mental disturbance which one does not treat by fiat. The family doctor, suggested as another counselor-therapist, is often both untrained in psychotherapy and unfortunately skeptical about it; so is the public health nurse. Specifications for this whole motley treatment-crew suggest that the chance to do psychotherapy would attract every Nosy Nellie and every Peeping Tom who is in public employment or Boy Scout work.

It might be interesting to contrast the suggestions that all kinds of people be recruited for treatment with some actual experience in training—the training of public health nurses for a much easier task than treatment, that of applying mental hygiene principles in their relations with patients in their already existing duties. For details, one may consult the report of Kazan et al.* on a two-year program of teaching mental hygiene to 108 Westchester County (N.Y.) public health nurses. The authors found that 59 had increased insight, but that only 15 of these were able to apply it usefully, while 49 appeared to have gained nothing, and six of these 49 were more resistive to mental hygiene principles than before they started the special training. The nurses with more than average (mean) experience were more resistive than their younger colleagues. The training was in the principles of mental health and their application, with any problems to be referred to a special nurse or social worker or mental health consultant, who, in turn, would presumably move to arrange treatment when necessary. Would the Joint Commission seriously propose (on second thought) that any one of these 108 Westchester public health nurses—even the 15 who handled their medical patients better—undertake the treatment of mental illness?

*Kazan, Avraam T.; Ostrow, Ellen K.; Cummings, Ruth, and Kline, Milton V.: Teaching mental hygiene: a problem in resistances. PSYCHIAT. QUART. SUPPL., 27:1, 1-21, 1953.

Cumming called the attention of the Hospital Institute panel to another recommendation for recruiting psychotherapists, one made elsewhere than in *Action for Mental Health.* That is, that psychiatrists may well extend their effectiveness if they will train others, including "sub-professionals," to work as extensions of themselves. Cumming asked how many psychiatrists would be willing to work through others much of the time, how many were fitted to do so, and how many had the skills to train these personality-extensions. THE QUARTERLY would ask also how these non-professionals are to be trained in addition—supposing they learn to do psychotherapy—to professional standards of respecting their patients' confidences.

The doctor takes a solemn oath not to disclose what ought not to be disclosed; the attorney must not disclose what his client tells him; and the clergyman may be laid under a similar obligation. This obligation is, on the whole, observed both in principle and practice; and the courts respect it. If others are to act as the physicians' extensions, however, how long can it be supposed that the left hand will be kept ignorant of the right hand's doing? If still others are to do psychotherapy, not as psychiatrists' extensions, but under more or less loose medical supervision, how long can it be supposed that they will keep the fascinating things they learn strictly to themselves? And what attitude will the courts take when a county farm agent pleads that a communication from a client is privileged, and that he cannot be forced to disclose it? The courts have been generally unsympathetic when journalists have pleaded privilege to protect the sources of their information, although their privilege may be vital to a fundamental American liberty, freedom of the press.

A practical note on the training of laymen in matters psychiatric may be found in "A Mental Health Survey of Older People," conducted in Syracuse, N. Y., by a special staff of the New York State Mental Health Research Unit.* The unit's 10 interviewers were made up of five fourth-year medical students, three graduate social casework students, one graduate social science student (of history), and one professional public health worker—all but one with some medical or allied professional

*Staff of the Mental Health Research Unit: A mental health survey of older people. PSYCHIAT. QUART. SUPPL., 33:1, 45-99; 33:2, 252-300; 34:1, 34-75, Parts 1 and 2, 1959 and Part 1, 1960.

training. It required 14 days of intensive work to train them to interview a not-too-heterogeneous population of 65 or over to estimate the incidence of the mental disorders of old age and to estimate the incidence of certifiable disorder. A careful psychiatric check indicated reasonably reliable results; but a glance at the survey report will suggest that nobody but a psychiatric idiot would expect even these carefully selected people to undertake treatment. Teachers and sheriffs?

How freely are people under severe emotional strain going to talk to a teacher, whose profession requires him to rise superior daily to his pupils' difficulties? How freely will they talk to a judge whose business it is to pronounce the law; or to a probation officer, whose business it is to return relapsed sinners to prison? If they do talk freely, what will be the effects when waves of gossip spread about such juicy personal affairs as hatred for a parent or a child, adultery of a wife, impotence of a husband, promiscuity of a high-school girl, homosexual impulses, incest, frigidity, worry over masturbation, secret drinking, drug-taking, wife-beating, or gambling in secret? Every sort of problem from the criminal to the trivial is likely to come to the psychotherapist; psychotherapists are human; and humans are generally indiscreet—with such exceptions as those noted by constraint of religious dedication or the Oath of Hippocrates. It should be emphasized again that the Joint Commission proposes that whole categories of oddly-assorted laymen, not only counsel or advise, but treat—the *Action for Mental Health* discussion calls for "the earliest possible treatment."

THE PSYCHIATRIC QUARTERLY is as fully convinced as is the Joint Commission of the need for early detection and treatment of incipient mental disorders of all kinds. But it is equally convinced that in this instance—as in others on which it has commented previously*—the commission has not thought through the problem, and has presented a "solution" which is highly undesirable.

THE QUARTERLY believes that a scant handful of counselors can be recruited from some of the groups the Joint Commission names, but that they will need to be selected with great care for personality traits and competence in managing people, and that they will need intensive and expert training (some of the clergy have

*Editorial: "No Originality of Proposition or Proof." PSYCHIAT. QUART., 35:3, 576-585, July 1961.

it already). Further, when they have been trained, they should confine themselves strictly to counseling—to listening, to giving support, and to advising on matters where there is a plainly conscious interpersonal or environmental problem susceptible of influence by reason. They should be taught the signs and symptoms of incipient neurotic or mental disorder and taught to refer such instantly to a professional trained to deal with them. They should be laid under solemn obligations to respect confidence and should have some sort of legal protection, or at least limited privilege, in this regard.

These people should on no account give, as the Joint Commission suggests, "the earliest possible treatment"; that is, they should practise no kind of psychotherapy. This journal believes that *no* psychotherapy is to be preferred to *bad* psychotherapy, which may exacerbate neuroses and precipitate psychotic episodes. It also believes that without the minimum of intensive training suggested here for counselors, the signs of incipient mental disorder are likely to be undetected, and disastrous counseling may follow. Such syndromes as pseudoneurotic schizophrenia, for example, have often escaped the detection of the psychiatrist himself, sometimes with dire consequences; it would not be amusing to have county agents and parole officers trying to treat them!

Many more psychiatrists for community work are urgently needed. But THE QUARTERLY believes that they will have to be trained professionally—arduously and slowly. No builder would attempt to cope with a shortage of carpenters by collecting farm hands, shipping clerks and college freshmen, calling them carpenters and sending them out on the job. Neither should we meet a shortage of professionals by calling all sorts of half-trained or untrained people psychotherapists and sending *them* out on the job. One cannot fill gaps in professional ranks by calling two-spots "aces"!

—THE EDITOR

BOOK REVIEWS

Somatic Treatment in Psychiatry. By LOTHAR KALINOWSKY, M.D., and PAUL HOCH, M.D. 346 pages. Cloth. Grune & Stratton. New York. 1961. Price $9.75.

This should be considered one of the important books reviewing somatic treatments and is valuable to all psychiatrists, as well as to psychiatric libraries.

The volume contains revised parts of a previous book by the same authors, *Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry.* The greatest advantage of the book reviewed here is the chapter of 123 pages reviewing and discussing the many newer drugs used by psychiatrists. Fifty-seven pages are spent on a discussion of the phenothiazines alone. The remaining sections review the convulsive therapies, psychosurgery and various pharmacological and other methods. The book has a tremendous bibliography.

The authors close the book with a chapter, "Theoretical Remarks," in which they try to analyze how the various methods work physiologically.

They say of somatic treatments in general: "... most of them are poorly understood, or even entirely obscure in their mode of action. The expectation that the newer somatic treatments would throw some light on the etiology of the mental disorders for which they are applied, has not yet been fulfilled. At present, we can say only that we are treating empirically disorders whose etiology is unknown with methods whose action is also shrouded in mystery."

Current Psychiatric Therapy. Vol. 1, 1961. JULES H. MASSERMAN, M.D., editor. 246 pages. Cloth. Grune & Stratton. New York. 1961. Price $7.50.

This book is the first of an annual series. As in any volume with numerous authors, the articles vary in quality and content. The practising psychiatrist will find nothing new in it, but the resident or person in allied fields to the psychiatric may find much useful material.

The book is divided into sections: preventative psychiatry, the child, psychophysical methods, group treatment, aftercare programs, and psychoanalysis. Interesting articles include one on verbal signals, and a paper on simultaneous therapy with couples. The article on short-term analysis would lead one to believe that this was a new therapy, rather than one which had been practised for several decades. The bibliographies following each article are excellent. For library use and teaching, this book is to be recommended.

Contemporary Psychotherapies. MORRIS I. STEIN, editor. 386 pages, including index. Cloth. Free Press of Glencoe. New York. 1961. Price $7.50.

Ten outstanding psychotherapists contribute 19 papers which were originally presented as a series of lectures at the University of Chicago in 1958 and 1959. The diverse orientations represented are Adlerian, client-centered, Existential, interactional, interpersonal, psychoanalytic, reparative-adaptational and transactional. Re-evaluation of theories, examination of specific problems in therapy, case discussions and the presentation of research studies make this volume particularly valuable for both student and professional who are interested in, or involved in, psychotherapeutic relationships.

This Difficult Individual, Ezra Pound. By EUSTACE MULLINS. 388 pages, including appendix of chapter footnotes and index of proper names. Cloth. Fleet. New York. 1961. Price $5.00.

Eustace Mullins, described on the dust jacket as "painter, poet, photographer and sculptor," a descendant of the first families of Virginia, says he first met Ezra Pound when—as a student in Washington—he found a way to visit the poet, then a patient at St. Elizabeths Hospital; he became a constant caller, and (quite evidently) a disciple. He was certainly both a trusted intimate and a fervent admirer; and his picture of Pound—from daily conversations and frequent reminiscences—is one of a fascinating figure. Pound, in his youth and early middle age, was a leader and teacher of a whole generation of American and English writers, and Mullins' wholly admiring biography is testimony to the poet's acuity and magnetism in old age, treason charges and psychopathology notwithstanding. Mullins visited Pound for three hours daily over a period of years.

To review this book adequately, it is necessary to establish the author's frame of reference. Pound, says Mullins, "risked the death penalty in order to defend the Constitution of the United States" in his wartime broadcasts from Rome over a government-owned enemy radio. Mullins describes the "dank, dark buildings" of St. Elizabeths as reeking with "the foul stench of a century's urine," and finds that its "inmates" include "assorted rapists, dope addicts, and political prisoners"—in the third category, of course, Pound was one. "It has been very simple," says Mullins, "for bureaucrats to designate their critics as being 'mentally ill,' and to shut them away from the eyes of the world in the various Bastilles that have been built for that purpose." Two of the four psychiatrists who reported to the court that Pound was "insane and mentally unfit for trial," Marion R. King and Winfred Overholser, were "career" bureaucrats, government officials, Mullins remarks, adding that it seemed that "the deck was stacked."

That Pound's mental condition, established in part by these bureaucrats, saved him from trial and conviction for treason, Mullins does not grant for a second. He prints abundant excerpts, however, from Pound's Rome

broadcasts and wartime writings which, this reviewer thinks, any jury would hold, constituted treason.

A few quotations from transcripts of broadcasts (as presented by Mullins) during 1942 and 1943, in the first year of which America's back was to the wall, will serve to illustrate; the page references are to the present book: "I don't think the claim of even going through the motions of inviting [invading according to transcriber (Mullins' brackets)] Russia to slaughter and kill all Eastern Europe is a necessary part of the program [p. 207]." "The President has no more legal right to do these infamies ... [p. 208]." "... the prospect of a thirty years' war is not one to arouse mirth and hilarity, even in ... irresponsible people such as the United States of Americans [pp. 208-209]." "The place to defend the American heritage is on the American continent and no man who had any part in helping Franklin D. Roosevelt to spill out—get the United States into it—has enough sense to win anything [p. 209]." "... dung floes of Wall Street and of Washington, ...[p. 213]." "And of course you ought not to be in this war, even to cover up the grievous failure of the administration to govern the United States, let alone fixing up the affairs of Europe and Asia [p. 220]." And "... Mr. Roosevelt's war ... [p. 228]."

It is difficult to imagine a jury which would not consider this sort of thing—over an enemy radio in the midst of a bitter conflict—as giving aid and comfort to the enemy, which is defined as treason in the Constitution of the United States. Pound's possibly idealistic purpose and lofty aim are entirely irrelevant here, though they may be relevant to his psychopathology; more than one psychopathic fanatic has wrought harm with high intent for the greater glory of God. Pound's friends, though not Pound himself, who seems to have sought martyrdom, should have welcomed the psychiatric intervention that saved him from trial, instead of representing psychiatry—as Mullins does—in terms seldom heard from anyone but a paranoid psychotic on a disturbed ward. This reviewer thinks it would have been a lasting disgrace to try, let alone execute, a psychotic and is happy that time has permitted Pound's release as harmless to the United States—regardless of his mental condition.

One may, nevertheless, be grateful to Mullins on several counts. For one thing, he gives a partial guide to the trivial episodes and long-forgotten minor scandals of the literary set of Pound's earlier years, which are the subjects of otherwise cryptic references in the otherwise generally incomprehensible Pisan cantos. For another, he paints a brilliant picture of the self-exiled poet, from the days when he strode through Europe, a modern Barbarosa with an emerald dangling from one ear, chief of the advance guard of the literary radicals, to his pitiable old age as a mental patient.

For the distortions in Mullins' picture, some are both so blatant and so weird as to alert any unsuspecting reader to watch for the obscure ones.

For instance: "At this time [1915] American sentiment was overwhelmingly pro-German," a statement that seems like supreme idiocy to anybody who lived through that time—Mullins had not yet been born. And, in comment on a 1941 Rome broadcast by Pound warning the United States not to provide aid to Great Britain, "Some eighty-five per cent of the American public, at that time, felt the same way." Mullins was only 17 or 18 then, and evidently no polltaker. One suspects the master's voice.

With the author's very peculiar point of view well in mind, *This Difficult Individual, Ezra Pound* is to be commended both to the student of literature and the student of psychiatry; the latter will perceive a thread leading from spectacular and presumably consciously intended eccentricity all the way to the severe derangement the examining psychiatrists found late in 1945.

Physician: Healer and Scientist. By DANA W. ATCHLEY. 129 pages. Cloth. Macmillan Career Books. New York. 1961. Price $3.50.

This is one of a series (Macmillan Career Books) of small books designed to provide information about the various professions and vocations. Emeritus Professor (clinical medicine, College of Physicians and Surgeons, Columbia) Atchley recites not only the usual medical historical material and curricular facts, but has seized the opportunity to ventilate some very positive personal opinions and a few controversial views. Atchley evidently is unregardful of Whitehorn's observation that the orientation and activities of the clinical physician on the one hand and of the scientist on the other involve irreconcilable differences of philosophy and purposes.

Atchley is pretty specific about his orientation toward doctors. It is pretty clear that when he speaks of physicians, he is thinking of internists; and, let there be no misunderstanding about this, his internist is no general practitioner. He has nothing but contempt for those poor fellows upon whose shoulders the greatest burden of medical care rests. For Atchley these are practitioners of "desert medicine." Atchley directs a scornful glance into many a nook and cranny. The state medical schools come in for their share of it and so do hospitals other than those connected with teaching institutions.

This dogmatic approach belongs to the arrogant period before medical schools became aware that the social image of the physician had deteriorated and that medicine no longer had the pulling power to attract the best students. The book does not make any attempt to grapple with any of the important social and economic questions, uncertainty about which is deflecting many promising candidates from a field in which they are needed. It is not written in a vein sympathetic toward the efforts of public servants who struggle to do the best they can with what little they have, and it is not characterized by a realistic attitude toward practical matters.

The Image of Love. By CLEMENS E. BENDA, M.D. 206 pages. Cloth. The Free Press of Glencoe. New York. 1961. Price $5.00.

This is a collection of seven essays, only the first of which deals directly with the problem of love. One might subhead this textbook "A Psychiatrist Turns to Philosophy."

In his essay on sexuality and love, the author ends by asking, "What is man? What is man in love?"

His essay on language and communication is excellent, but has nothing particularly original or new. The chapter on the spectrum of emotion deals mainly with a case study and is in the opinion of this reviewer the weakest chapter in the group.

As an auxiliary book and for additional reading, many will find this useful and provocative. It cannot be used as a text, however, for a psychiatric understanding of sex and love.

Problems of Addiction and Habituation. PAUL H. HOCH, M.D., and JOSEPH ZUBIN, Ph.D., editors. 250 pages, including index. Cloth. Grune & Stratton. New York. 1958. Price $6.50.

The proceedings of the forty-seventh annual meeting of the American Psychopathological Association held in 1957 are reported here. This symposium deals with the various approaches to the serious problems raised by alcoholism and drug addiction. The all too familiar medical and frustrating legal aspects are given a going over, and avenues for research and therapy are explored.

Seed in the Wind. By L. O. GRIFFITH. 208 pages. Random House. New York. 1960. Price $3.50.

Seed in the Wind is a well-meaning, though badly written novel about the South. The obstinate white ("It won't happen here. Because God made black and He made white and them sonofabitches on the Supreme Court can't change what God made"), the compromising and scared Negro, and the rebellious Negro are described. The reviewer thinks that the author has no conception of unconscious mechanisms.

To Kill a Mockingbird. By HARPER LEE. 296 pages. Cloth. Lippincott. Philadelphia. 1960. Price $3.95.

A pro-Negro book is written by a white woman from the South. The time is 1935, the place Alabama; the real hero is an elderly white lawyer who dares defend a colored man, unjustifiably accused of rape. This book has received rave reviews, although the reviewer thinks it mediocre. A good novel requires more than sympathetic presentation.

Pavlovian Conference on Higher Nervous Activity. NATHAN S. KLINE, conference editor. 25 authors. 383 pages. Paper. New York Academy of Sciences. 1961. Price $5.00.

This is a formal report emanating from a meeting of speakers invited, on the one hand, by the New York Academy of Sciences and, on the other, by the Academy of Medical Sciences of the U.S.S.R., to consider the relationship of neuroanatomy and neurophysiology to behavior. The papers are grouped into sections which are not by any means subdivisions of a consistent system. These sections are "Structure and Function," "Cortico-Subcortical Interaction," "Deviance and Drugs," "Irradiation and Generalization," "Psychopharmacology and Inhibition," but it is far from clear why certain papers were placed in one category and not another. Probably the most interesting aspects of this conference are the extent to which Pavlovian theory has been adopted in this country and the distance which has developed in Russia between present-day experimental procedures and classical Pavlovianism.

Progress in Neurology and Psychiatry. E. A. SPIEGEL, M.D., editor. Volume XV, 606 pages; Volume XVI, 601 pages. Cloth. Grune & Stratton. New York. 1960 and 1961. Price per volume, $12.75.

It is impossible to do other than praise the effort and work which the contributors have made in preparing these yearly volumes covering the advances in neurology and psychiatry. These books are extremely important sources of references. They cover content briefly of each article reviewed, and note exactly where each article can be found. These volumes should be in all libraries used by neurologists and psychiatrists.

Pioneers in Mental Health. By ROBIN MCKOWN. 234 pages. Cloth. Dodd, Mead. New York. 1961. Price $3.25.

Mrs. McKown, a biographer of such persons as Marie Curie, Irene Joliot-Curie and Frederic Remington has now written what should be a very popular book, containing the biographies of the "Pioneers in Mental Health." Her book is pleasant and easy reading. It describes the lives, the acts and the ideas of such persons as Pinel, Mesmer, Rush, Turk, Dix, Charcot, Freud, Beers and Meyers.

Goodbye To Some. By GORDON FORBES. 288 pages. Cloth. Norton. New York. 1961. Price $3.95.

A naval bombing squadron flies what to this reviewer seem ridiculous distances with overloaded planes, to find enemy ships and shipping.

This reviewer found naval flying jargon hard to comprehend, and use of the first person makes for report-like, monotonous reading.

The Fault of the Apple. By FREDERIC WAKEMAN. 253 pages. Cloth. Simon and Schuster. New York. 1961. Price $3.95.

Frederic Wakeman is the author of *The Hucksters* and *Deluxe Tour,* and one may expect that a book by him will be written primarily for the movie-going public. His characters, the reviewer feels, are poorly developed. Changes of scene from America to Europe and the development of a love affair, with movement back and forth between mistress and wife, although excellent for moving pictures, make poor psychological material.

Human Behaviour. By CLAIRE RUSSELL and W. M. S. RUSSELL. 532 pages, including index. Cloth. Little, Brown. Boston, Toronto. 1961. Price $6.50.

The authors, husband and wife, are lay analysts. He has a background in the classics, English literature and zoology. The book presents a theory of human behavior which is inspired by psychoanalysis, above all by the ideas concerning the effects of early child-parent relationships. More emphasis is placed on power relations than on the sexual instinct and its vicissitudes. The authors' general classification of personality is in terms of degree of identification with the parents. "The creation of irrational automatism takes place in two stages. In the first stage, the individual represses his parents' hostility and sees himself as they saw him. In the second stage, the individual takes over the parental identifications completely; he now sees himself as his parents saw themselves, and he sees others as his parents saw him."

The first phase (which can last a lifetime) is idealistic: Success or failure is measured by the extent to which the idealist can satisfy an exploiter. The second phase (which can also last decades) is cynical: Success is measured by ability to exploit others. The idealist is creative and destructively self-critical. The cynic is destructively critical of others, but suffers in that he cannot enjoy himself or be creative.

The authors illustrate their concepts with a great multitude of examples taken from clinic, classical and more modern literature; history, ancient and modern politics; and ethological studies of birds and frogs.

The arguments are not tight, systematic or succinct (which explains the large size of the book), but they make for easy, clear, albeit rambling, reading.

The authors try to distinguish between automatic or instinctive behavior (most readily observed in lower animals), and self-conscious and self-critical "intelligent" human behavior. There is a great deal about the numerous varieties of exploitation of children by their parents.

This book is for the reader who can afford to read at a leisurely pace. There are many diagrams and a 13-page index. The most valuable part is the elaboration of the concept of the idealist and the cynic—one might say of the eternal pair of Don Quixote and Sancho Panza.

Ourselves to Know. By JOHN O'HARA. 408 pages. Cloth. Random House. New York. 1960. Price $4.95.

The reviewer thinks that two features are remarkable in this book by O'Hara: First, that the author of such brilliant novels as *Appointment in Samarra* and *Butterfield 8*, is capable of writing a dull, boring, psychologically unsound book; second, that having obviously lost his intuitive set of psychological directions, the author clings to superficial psychological "book-knowledge." The result is rather pathetic, and one wonders why writers whose good work one admired in the past, have to embarrass their past adherents with poor productions in the present.

The hero of *Ourselves to Know* is a nondescript, rather stupid, rather passive, provincial man, who at the age of 50 marries a 17-year-old girl, some kind of half-nymphomaniac, who starts a conspicuous affair in their small town; the husband finds out, kills her, and is acquitted. Obviously, a psychological background has to be provided, and at that point the interminably long and boring book fails.

The Purveyor. By JOHN STARR. 265 pages. Cloth. Holt, Rinehart and Winston. New York. 1961. Price $4.95.

This is an interesting and informative book about "today's illicit liquor empire." The author is a journalist, the narrator an old gangster who, for reasons of his own, wants to confess—anonymously. A good deal of seemingly authentic material is reported. The author has some psychological knowledge, and suspects the compulsion to confess because of unclear guilt, but does not see the masochistic basis.

The Grand Parade. By JULIAN MAYFIELD. 448 pages. Cloth. Vanguard. New York. 1961. Price $4.95.

A young Negro novelist assembles a long series of usable situations: politics, school segregation, Negro middle-class people, agitators, ex-Communists. Even the locale is well chosen—a borderline city of 100,000, used as a field for experimentation by out-of-town anti-segregationsts, to create an artificial riot. Unfortunately the author creates only papier-mâché characters.

Stacked Deck. By FRANK KANE. 192 pages. Paper. Dell. New York. 1961. Price 35 cents.

Substandard and psychologically naïve detective stories feature the tough, killing, slugging detective; his only discernible mental activity is admiration for redheads.

Night. By FRANCIS POLLINI. 305 pages. Cloth. Houghton Mifflin. Boston. 1961. Price $3.95.

An interesting novel centers around the brainwashing by Chinese of American prisoners of war in Korea. One man holds out, and his attitude is well described though not explained.

The Long Gainer. By WILLIAM MANCHESTER. 495 pages. Cloth. Little, Brown. Boston. 1961. Price $4.95.

A novel, written with journalistic skill and psychological ignorance, centers around the fight between a New England state university and a gray flannel college of the ivied halls type, mixed up in a political campaign. The people populating this novel are simply types.

Explorations of a Hypnotist. By JONATHAN RODNEY. 166 pages. Cloth. Associated Booksellers. Westport, Conn. 1959. Price $4.00.

Rodney is evidently a British practising allergist. The first part of his book, which is intended for the layman, is devoted to an account of medical hypnosis with some asides in which the author subscribes to a belief in extrasensory perceptual experience and the psychic influence of colors. The second part is concerned with cases to illustrate regression under hypnosis. The material in this section is organized in such a way as to suggest that hypnotic regression evokes memories of previous incarnations which have been stored in the unconscious.

Trust in Chariots. By THOMAS SAVAGE. 273 pages. Cloth. Random House. New York. 1961. Price $3.95.

This is a novel with a good theme and poor execution: A man leaving his faithless wife and a young boy leaving his tenement dwelling after his mother's death, are heading west; they meet and "take care" of each other. The author derives his action from a reversal of roles: the adult male's idea of adopting the boy changes into the boy taking care of the protector. The situation is filled with complex psychological possibilities which the author makes nothing of.

Sleep Therapy in the Neuroses. By B. V. ANDREEV, M.D. 114 pages. Cloth. Consultants Bureau. New York. 1960. Price $8.50.

This monograph has value primarily as an exposition of a method of treatment as practised by a psychiatrist in the Soviet Union. The reviewer could not help but be impressed by the crudity of the method and the restrictive frame of reference that is employed. There are inferences drawn about "fatigue of nerve cells" with substantiation of this fact offered by limited clinical observations in a rigidly structured environment. No attempt is made to correlate method and results with any frame of reference other than the Pavlovian, and no controlled experimental precedure is utilized to compare or contrast the efficacy of sleep therapy with exactly the same type of milieu therapy without sleep treatments.

There is a fairly complete bibliography, if one includes the supplementary one compiled by Dr. Joseph Wortis.

The People of Alor. By CORA DUBOIS, with analyses by ABRAM KARDINER and EMIL OBERHOLZER. 654 pages including index. II vols. Harper. New York. 1961. Price $1.95 each.

This is a soft cover (Harper Torchbook) edition of the excellent psychosocial study of an East Indian island by a team of experts under the direction of Cora DuBois, an anthropologist. It was the first such attempt by so wide a team in the study of human nature. This edition retains the photographs and illustrations of the original. Among the interesting parts of this contribution, are the successful blind analyses of the Rorschach records of 38 Alorese by Oberholzer; their success strongly suggests that the basic Rorschach components and their psychological definitions are not culture bound. Psychoanalytically oriented interpretations of dreams and of autobiographies, analyzed by Kardiner, are another instructive part.

Dr. DuBois did most of the work herself. This model study of a simple society contains many novel and valuable methodological advances, and will, no doubt, be a landmark in cultural anthropology.

Children of the Evening. 54 pages. Paper. University of Texas Printing Division. Austin. 1961. Price 25 cents.

This pamphlet was written under the auspices of the Hogg Foundation for Mental Health and is a review of the need for treatment of the emotionally disturbed child and various types of facilities that can be used. It is geared to the lay public and is satisfactory for educational purposes.

Freud and the Post-Freudians. By J. C. BROWN. 225 pages with bibliography and index. Paper. A Pelican Book. Penguin Books. Baltimore. 1961. Price 95 cents.

Dr. Brown is a writer on psychiatry and psychology. He holds a medical degree and served as a psychiatrist in the Middle East in World War II. He considers his own position to be within the limits of Freudian orthodoxy.

In *Freud and the Post-Freudians,* he has produced an excellent outline of the history and present status of psychoanalysis and the schools derived from it. It is not only a good book; it may easily become an important one. A reasonably objective view of Freud's own development of his theories from their beginnings until his death, and a reasonably objective view of the divergent schools which rose from psychoanalysis after his death—from the frank seceders to the neo-Freudian—are two things exceedingly hard to come by. Dr. Brown seems to provide both. This book can be recommended for general reading; and it would serve as an admirable introduction for the serious student.

Freud and Psychoanalysis. The Collected Works of C. G. JUNG. Volume 4. 376 pages. Cloth. Pantheon. New York. 1961. Price $5.00.

Freud and Psychoanalysis comprises the papers written by Jung on psychoanalysis while he was still collaborating with Freud, and his further writings covering the break with Freud and his view of its causes and the events of its development. The book belongs in any library, psychoanalytic or otherwise, which pretends to cover source material on the history of psychiatry.

The Hunter Deep In Summer. By EDWARD LOOMIS. 201 pages. Cloth. Viking. New York. 1961. Price $3.75.

The reviewer considers this novel to be a groping attempt to deal with middle-age revolt. A retired lawyer in a small California community takes the case of two Indians accused of murder. He is revitalized—especially by an affair he starts—to end up contemplating the sadness of life. The story and description are weak, the feeling behind them rather genuine.

What a Girl Should Know About Sex. By BERNHARDT S. GOTTLIEB, M.D. 190 pages including index. Cloth. Bobbs-Merrill. Indianapolis. 1961. Price $3.25.

This is a clearly written, understanding and informative volume for a young girl about the "facts of life." Dr. Gottlieb answers real questions from his psychiatric practice with teenagers in a sensitive and astute fashion.

The Best of Best Cartoons. 20th Anniversary Edition. LAWRENCE LARIAR, editor. Crown. New York. 1961. Price $4.95.

Lariar has picked what he considers the 500 best cartoons of all he has printed in the best cartoons of the year series, starting with 1942 and ending with the cartoons of 1961, which have not previously been seen in book form. There is a short and lively introduction by Stephen Longstreet, and notes of considerable sardonic insight introducing each year's cartoons in their political and social setting.

Lariar's cartoon annual is always a clever collection, and he has outdone himself with this issue. The reviewer misses Chas Addams and presumes that either copyright difficulties or the editor's conviction that Addams isn't funny—the aim was to produce a laugh-inspiring collection—is responsible. This is a fine gift book, or a splendid waiting-room-table book—for a doctor with sufficiently sophisticated patients. This has been remarked of Lariar's previous collections and doubtless will be in future. Psychiatry comes in for more than an ordinary share of left jabs—most of them in the spirit of fun.

The Concept of Method. By JUSTUS BUCHLER. 180 pages. Cloth. Columbia University Press. New York. 1961. Price $4.00.

Professor (philosophy, Columbia) Buchler here follows his systematic *Toward a General Theory of Human Judgment* and *Nature and Judgment* with a further application of inquiry into historically important writers on intellectual methods. "The present study asks what makes any of these 'philosophic' methods 'methodic.'" Buchler develops his conclusions principally in the form of dissensions from the approaches of such writers as Descartes, Bentham, Coleridge and Whitehead. No single acceptable method is developed by Buchler for the reason that, being a philosopher, his aims must, of necessity, transcend any particular method. Moreover, as he points out, methods only have utility in terms of purposes, and philosophers are not likely to be content with the purposes of scientists or artists.

Psychiatric Social Work. By ROY R. GRINKER, SR., et al. 338 pages. Cloth. Basic Books. New York. 1961. Price $6.50.

The work presented in this book represents a final analysis of the results of a 10-year research effort by Dr. Grinker and associates at the Michael Reese Hospital and Medical Center, Chicago. The initially designed research task, as stated by the authors, was to determine the answers to two basic questions. What does the psychiatric social worker do with his time in the psychiatric clinic and hospital? How does he use his knowledge and technical skill in serving his patient's needs?

Through analysis of clinical experience, well represented by material from 23 cases, several major observations are made as the transactional system of work with patients is developed. A clear departure is made from the psychoanalytic model; and emphasis is placed upon the immediate social matrix of the patient, the value of countertransference phenomena when recognized by the therapist, and the utilization of the total life "field" of patient and therapist. Communications and information theory, role theory and field theory are incorporated in the design of the transactional system. It is stated that "... although we may profit by understanding psychodynamics, according to the psychoanalytic model, this is not adequate for understanding the immediate transactions operationally within a psychotherapeutic interview."

In answer to the initial research question as to how the social worker functions in the clinic or hospital and what service he provides, the authors state that there is no longer any sharp division of labor; no completely separate and distinct role to be assumed by the social worker. This is to say merely that there is considerable overlapping of function on the clinic or hospital team.

The transactional approach is differentiated from those systems of therapy closer to the psychoanalytic model by the fact that work is done with

derivative conflicts and there is no specially strong interest in uncovering the co-called primary conflicts. Of critical importance to successful implementation of the transactional system is the worker's sensitivity to implicit or subsurface roles assumed by the patient and by himself and his ability to recognize these roles and use them effectively. Only two and one-half pages are devoted to understanding and interpreting implicit roles, despite the fact that without this skill very little success may be realized.

The transactional casework approach presents a theoretical structure which incorporates both new and promising concepts and more established methods which have proved their reliability. However, its effectiveness, as is the case with any system of therapy, is dependent upon the particular skills of those who utilize it. The problem of teaching necessary skills to new therapists is not made any easier or less time-consuming by this writing.

The Cry For Help. NORMAN L. FARBEROW, Ph.D., and EDWIN S. SHNEIDMAN, Ph.D., editors. 398 pages including index. Cloth. McGraw-Hill. New York. 1961. Price $9.95.

Traitor Within. By EDWARD ROBB ELLIS and GEORGE N. ALLEN. 237 pages including index. Cloth. Doubleday. New York. 1961. Price $3.95.

The two volumes reviewed here present scientific and popular material on our present knowledge of suicide.

The title, "The Cry for Help," is intended to symbolize the work of the suicide prevention center at Los Angeles, an endeavor with which both editors are connected. It includes a review of the work of this center and discussions covering various aspects of suicide and attempted suicide. Heinz L. Ansbacher, Louis E. DeRosis and Herbert Hendin are among the contributors. This is a basic book for teaching and reference, and it includes a most useful bibliography from 1897 through 1957.

Traitor Within is a presentation for general reading of suicide as a national health problem. As Farberow and Shneidman's book makes use of experience in suicide prevention in Los Angeles, this volume leans on FRIENDS, an experimental suicide prevention group in Miami. It gives practical and detailed information concerning the operation of this group, including its training guide for workers. Ellis and Allen are both New York City newspaper reporters. They have done an excellent research job and their material generally can be relied upon. The authors' preface states that they have spent 15 years in research. The presentation, however reliable, is nevertheless published without the specific and detailed documentation which a scientific work must have and which the authors certainly could supply. This book is excellent mental hygiene and can be recommended for general reading.

Frontiers in General Hospital Psychiatry. LOUIS LINN, M.D., editor. 483 pages including index. Cloth. International Universities Press. New York. 1961. Price $10.00.

Dr. Linn has edited a useful and most interesting book. With contributors from all over the world, he has selected material ranging from a discussion of the integration of services at the York Clinic of Guy's Hospital, London, to general hospital psychiatric services in the United States, in Europe, in the Soviet Union and even in Africa—where a village system of treatment in Nigeria is discussed. There are too many notable and useful contributions for enumeration, but Ruth Fox' paper, "The Alcoholic in a General Hospital"; Marie Nyswander's "The Drug Addict in a General Hospital"; Joseph Epstein's "The Impact of the General Hospital on the Private Psychiatric Hospital" and Eleanor Clark's "Social Casework in a General Hospital" should be mentioned. There is a useful appendix in the form of a laboratory manual for general hospital psychiatry. This book should be widely read by psychiatrists generally, not merely by those in the general hospital field.

Bibliographic Sources of Existential Thought. By ARTHUR BURTON and DONALD T. LUNDE. 52 pages. Paper. Mimeographed, unbound. Agnews State Hospital. Agnew, Calif. 1961. Price 50 cents.

This bibliography covers sources of existentialist thought in art, literature, philosophy, psychiatry, psychology and theology. Dr. Burton, who is chief psychologist at Agnews (Calif.) State Hospital, states in his introduction that the aim of the authors was to cover all the fields in which existentialism has become a major force. He says the authors make no claim to definitiveness. A limited number of copies is available; and issues may be obtained from Dr. Burton for a 50-cent mailing charge each. The bibliography should be well worth this modest cost to any library or professional worker whose interests touch on existentialism.

Her. By LAWRENCE FERLINGHETTI. 157 pages. Paper. New Directions. New York. 1960. Price $1.25.

For this reviewer's ha'pennies, *Her* is an incoherent effort, in schizophrenically arranged sentences of up to 400 words, to outdo Henry Miller. It is presumably psychological—stream of consciousness or, perhaps, of what the author thinks is psychosis—and any psychologist who wants it can have it. It concludes "... I see green lights turn yellow in the mad brain dust the tar roofs bleed I see God grips the genitals to catch illusionary me stunned down in air of death's insanity to kiss me off he plays the deepsea catch he reels me in O god" Yes, the book gasps itself out without a period! Evil omen?

The Psychological Milieu of Lytton Strachey. By MARTIN KALLICH. 162 pages. Cloth. Bookman Associates. New York. 1961. Price $4.00.

The author of this book is concerned with (1) proving that Lytton Strachey's biographical interpretations were (a) essentially psychoanalytical exercises and (b) Freudian in origin and pattern, and (2) scolding Strachey's other biographers and critics for not being specific about these points. Since Kallich is able to reproduce a letter from Strachey's brother which substantiates point 1a it would seem that a brief journal note would have sufficed for purposes of recording. Since one does not ordinarily write a book to scold others for neglecting to insist upon something they may not have regarded as important, Kallich must have had some other reason for preparing this one. It would seem to be to ventilate the conviction that Strachey's was the correct approach to biographical writing. Indeed Kallich's global thesis is that "psychology can be employed to serve literature." Implicit, is the assumption that Kallich knows his psychology (and is thus provided with a status symbol in the literary world) and he does not hesitate to pass judgment (p. 20) upon what he believes to be the psychoanalytic dabbling of other critics of Strachey. There certainly appears to be more psychoanalyzing going on by do-it-yourselfers in the literary coffee houses than in medical circles!

Jane Jacobs has observed that a "city cannot be a work of art" because a city is a real, living thing, and a work of art is an abstraction *from* life. The same dilemma faces the biographer, and if Strachey's biographies have literary value they probably owe it to departures from fact, in which case his psychodynamic interpretations represent some deviations from the facts. However, if one is to depart from the facts, what difference does it make what avenues one chooses?

The air of primary certitude which one encounters among literary psychoanalysts is entirely foreign to the clinical approach. One would hate to have any reader of Kallich come away with the notion that his interpretations are reliable, that Freud was eternally consistent, that experienced psychoanalysts are in wide agreement, that tenable psychoanalytic conclusions are of necessity factual, that Strachey's biographies are not fictional (to speak of Strachey's "clinical insights," p. 103, is supererogatory), or that dabbling with psychoanalysis provides any writer or critic with a useful approach to literature.

Changes in Intelligence Quotient, Infancy to Maturity. By SAMUEL R. PINNEAU. 233 pages. Cloth. Houghton Mifflin. Boston. 1961. Price $4.60.

This book is a follow-up of the original Berkeley Growth Study. It covers four separate areas: the consistency of the intelligence quotient from infancy to late adolescence, the development of revised IQ tables, the

tabulation of changes with age, and discussion of the use of the tables. The sample is unfortunately small, and the main impression left is that there is an inconsistency in intelligence quotient scores whether the raw IQ, the deviation IQ or the percentile placement is used. Intelligence Quotient measurement still depends on so many variables that anything but an approximation cannot be expected. This must be used, in connection with psychiatric indications, in determining the mental status of an individual. The book will prove of interest mainly to psychometricians.

The Life and Work of Sigmund Freud. By ERNEST JONES. Edited and abridged in one volume by LIONEL TRILLING and STEVEN MARCUS. 541 pages including index. Cloth. Basic Books. New York. 1961. Price $7.50.

This is an abridgment, made and edited by Lionel Trilling and Steven Marcus, of Jones' definitive and exhaustive three-volume biography of Freud. There is an introduction by Trilling covering the purposes and procedure in making the abridgment. The one-volume edition omits what Trilling considers recapitulation in Volumes 1 and 2, and Jones' " 'historical review' of Freud's relation to and influence upon various intellectual disciplines. . ." in Volume 3. This is all material which does not strictly refer to Freud's life itself. The other omissions and compressions necessary to bring the original three volumes into 530 pages still leave a complete, readable and critical biography. Perhaps "critical" should be emphasized, since anti-Freudians have frequently alleged that Jones' biography is worshipful. Jones did not hesitate to be critical of Freud, and the criticisms appear in the abridgment. The abridged *Life* can be recommended for students and for general reading and would serve in default of the larger edition for reference purposes.

Perceptual Changes in Psychopathology. WILLIAM H. ITTELSON and SAMUEL B. KUTASH, editors. 262 pages. Cloth. Rutgers University Press. New Brunswick, N. J. 1961. Price $9.00.

Although this book does not touch on a large amount of material one would expect to find in a monograph with its title (there is no discussion of the development of perceptual change with the development of psychopathology or its disappearance with improvement), it is a significant book on a subject of importance to most readers of this periodical. The authors' material (Ittelson and Kutash were the editors of material gathered by a group of 17 authors, including themselves) was obtained through the study of visual perception in a psychiatric group at the East Orange, N. J., Veterans Administration Hospital. The Adelbert Ames, Jr. devices were employed in order to gather significant parts of the data (Chapters 5, 8, 11, etc.).

The volume is odd, in that the synthetic material precedes the experimental data, both in place in the book and, evidently, to a considerable extent in time of composition as well. This synthetic material is not highly original (perception involves a contribution from the personality doing the perceiving as well as from noumena) but, since it is relatively systematic and common-sense, it is practical and useful. Basic definitions are given. Mental health is conceived of as dependent upon perceptual flexibility. In line with this expression of the well-known rigidity of the schizophrenic was the finding that schizophrenics demonstrate a higher degree of size-constancy than do nonschizophrenics. "The ability of schizophrenics to comply with analytic instructions is related to their ability to separate a configuration from a complex field. The results suggest the greater perceptual rigidity of the schizophrenic as compared to the normal." Not all the experimental data are as clear as this example, and not all of the work has been completed. An effort was made in all the experiments to ascertain the degree of perceptual flexibility; and, on the basis of this capacity, Kutash has attempted to develop a prognostic index.

Town Without Pity. By MANFRED GREGOR. 241 pages. Cloth. Knopf. New York. 1961. Price $3.95.

A novel by a young West German writer explores the consequences of the rape of a young German girl by four American soldiers. The story attempts to prove Strindberg's dictum, ""Tis a pity about people." Light and shadow are evenly distributed; the author harps on the cruelty of small-town people. It is interesting to note that Hitlerism is hardly mentioned in the narrative, and the defender of the "good Germans" is an old Jewish lawyer.

A Modern Demonology. By FRANK GETLEIN. Illustrated by ROBERT OSBORN. 236 pages, including index. Cloth. Clarkson N. Potter, Inc. New York. 1961. Price $5.00.

This "... Social Criticism ... Complete with Sociological Findings ... on the Need for a Rehabilitation of the Ancient Science of Demonology, the Discovery and Destruction of Demons Inhabiting Various Individuals and Groups in the Social Order ..." is viciously brilliant in spots. There are particularly readable disquisitions on the demonology alleged to be involved in fanatical "law enforcement"; in A.M.A. policies; in the extremes of conservatism, liberalism, capitalism, segregationism, anti-Semitism, anti-Catholicism, and anti-Protestantism. The maverick labor unions and both major political parties get their shares of attention. The business of exorcism might have profited by reference to the work of the Rev. Montague Summers, for the demons appear flourishing at the end. Getlein's satiric language and Osborn's sardonic sketches also bring signs of fatigue in time; clever as their satire is, a book-length serving of it is too much; it is better taken by separate chapters.

The Farmers' Daughters. By WILLIAM CARLOS WILLIAMS. 374 pages. Paper. New Directions. Norfolk, Conn. 1961. Price $1.95.

As a tribute to the nearly octogenarian poet, New Directions collected 52 of Williams' best short stories. Reading (or re-reading) those, one finds confirmed what has been known for decades: the poet's (he is an M.D.) preoccupation with poverty, unhappiness, beauty found even in squalor. Characteristic is the dictum: "Let the successful carry off their blue ribbons; I have known the unsuccessful, far better persons than their more lucky brothers."

The Identity of Dr. Frazier. By GEORGE SKLAR. 289 pages. Cloth. Knopf. New York. 1961. Price $3.95.

An important novel on anti-Semitism, unfortunately full of psychological holes! A Gentile surgeon marries the daughter of a wealthy Jewish dress manufacturer and lives with her happily for twenty years; he is on the staff of a Jewish hospital in Los Angeles, and aspires to the position of chief of staff. To influence an important Jewish banker on the hospital board, he accompanies him on a fishing trip to Mexico with a few other Jewish friends; he gets drunk, makes anti-Semitic remarks, insults his wife, accuses everybody of being unfair, and so on.

The book's main thesis is that at bottom every "goy" is anti-Semitic, and the author's idea is that the unconscious comes out in a volcanic eruption; the author has never heard of "taking the blame for the lesser intrapsychic crime," in the case of his hero, anti-Semitism and half-homosexuality, to cover his masochism. The book is regrettable because it fosters old prejudices with pseudo-modern means.

An Introduction to Psychoanalytic Theory of Motivation. By WALTER TOMAN. 355 pages. Cloth. Pergamon. New York. 1960. Price $9.00.

The author successfully carries out the purpose of this book which is to explain psychoanalytic theories to those not oriented to psychology and psychiatry. He introduces the reader to the concepts of various desires, drives, defense mechanisms, and psychological mechanisms. He then applies these principles to the developing individual, stressing the early years of life, the latency period, adolescence and maturation. At the end, he introduces the reader to some case material.

This book is a well-written exposition of present psychoanalytic theory; but it gives the impression that psychoanalysis is proved fact, not theory, and that there is no other method of interpreting the development of the individual and the material presented. The existence of alternate theories and some exposition of the theoretical nature of psychoanalysis should have been included.

As an introduction to analytic theory, this book will be welcomed, however, by general college students and beginning psychologists.

What About Women. By JOHN HENRY CUTLER. 241 pages. Cloth. Ives Washburn. New York. 1961. Price $3.95.

This authority has here collected an array of fact, fiction and popular adage about females. He quotes experts like Errol Flynn. The reviewer found the book neither amusing, nor enlightening in any way.

Current Trends in Scientific Research. By PIERRE AUGER. 245 pages. Cloth. United Nations. New York. 1961. Price $6.75.

In 1958 the Secretary General of the U. N. was assigned the task of surveying main trends of inquiry in the natural sciences and the dissemination and application for peaceful ends of such knowledge. This work was delegated to Special Consultant Pierre Auger, former director of natural sciences of Unesco, and "a Special Advisory Committee composed of representatives appointed by the United Nations, ILO, FAO, Unesco, WHO, ICAO, WMO and the International Atomic Energy Agency."

The final report was prepared from material supplied by a considerable variety of sources and was submitted to key representatives from the United Kingdom, Russia, the United States and India. Since the operational portions of the report employ British spelling it is to be assumed that the key members of Professor Auger's staff were either British or that his report (which was printed in Paris) was translated from French into English by a British worker.

Possibly the most interesting feature of the report is the system of classification which was evidently forced upon Auger. This resembles a library cataloguer's system more than the traditional disciplines of college courses, and compels one to recognize conceptual realignments for which few of us have been specifically trained. This framework discloses an enormously complex system of compartmentalization, which has been enforced by a proliferating specialization. In this framework, there is no more place for the widely-trained, broad-gauge man than there is for the great auk. The useful natural scientist is obviously the fundamental or pure scientist who is also the master of a very narrow specific field. Such a man may not know much about political issues or esthetics and may not fulfill the classical definition of a member of a democratic society, but this is the sort of person who, in the thousands, has been responsible for the trends reported.

In such a report there is also relatively little room available for a discussion of the medical sciences, and thus of neuropsychiatry; but it is obvious from what *is* said that the times have changed so extensively that the type of training currently being required by certifying boards is already hopelessly out-of-date.

Mental Health, The Nurse and the Patient. By DORIS M. ODLUM, M.A. (Oxon.), B.A. (Lond.), M.R.C.S., L.R.C.P., D.P.M., Dip. Ed. ETHEL JOHNS, R.N., editor. 192 pages, including index. Cloth. Lippincott. Philadelphia. 1960. Price $3.90.

Dr. Odlum is a British psychiatrist who is author of a textbook, *Psychology of the Nurse and the Patient.* The volume reviewed here is an adaptation of the third edition of this book, made for North American use by the editor. It is designed to orient the nurse to her role in the application of mental health concepts to general duty nursing, and, in the opinion of the reviewer, it leaves a great deal to be desired. The book, poorly written and poorly organized, contains irrelevant material throughout. (An example is Chapter 14 which discusses nursing as a career.) Indicative of the poor organization, is a chapter dealing with the treatment of the psychoneuroses, in which a section entitled "Child Guidance" has been incorporated, although an entire previous chapter has already discussed the nursing of children.

This book, supposedly geared to help the nurse provide "emotional well being" for her patients, does not use a patient-centered approach to common problems in mental health. Instead, the emphasis is on physical treatment, with insulin, ECT, drug therapy, and so on, without even a mention of the role of the nurse in any of these procedures.

This book is of questionable value to any nurse, student or graduate, and the reviewer doubts that anyone, after reading it, will have increased "greatly her own efficiency and usefulness," an objective which appears to be the author's original aim.

The Living Symbol: A Case Study in the Process of Individuation. By GERHARD ADLER. 463 pages. Cloth. Pantheon. New York. 1961. Price $6.00.

The Bollingen Series is sponsored by the Bollingen Foundation, which is concerned with "symbolism, the history of religion, mythology, philosophy, psychology, cultural anthropology, archaeology, literary criticism, and aesthetics."

The Living Symbol is an account of a case of claustrophobia analyzed according to Jungian principles and techniques.

The author mentions the common objection to such an approach (Jung's "metaphysical, anthropological speculations suffered from the same defect as all theoretical constructions which consider man in general and no individual in particular") and tries to demonstrate that in the case of his patient the material can be specifically related to the individual discussed. The notions that the "data" could be a function of the observer and a product of the technique seem not to have occurred to him. The book will be found to be of interest chiefly to members of the Jungian school.

Minds That Came Back. By WALTER C. ALVAREZ. 384 pages. Cloth. Lippincott. Philadelphia. 1961. Price $5.95.

In his introduction, Alvarez (now emeritus professor of medicine at Minnesota and author of *Nervousness, Indigestion and Pain*) tells us that he "gathered what I imagine is the world's largest collection of autobiographies of people who have been mentally upset, highly eccentric, alcoholic, or otherwise ill or handicapped." Such collections are not uncommon but are ordinarily not made by psychiatric laymen like Alvarez and are usually developed for some scientific purpose. Alvarez, however, does not write for the cognoscenti but rather for the patient and his relatives. "Readers can find in the abstracts of these books, which I have gathered here into one volume, much hope and encouragement. Why? Because most of the authors show that, when nervously ill, we can often fight our way back to health and a useful life again." But the brusque head-on approach and breezy style are not likely to sit well with the distressed patient or his relatives. Moreover many of the "minds" whose productions are examined "came back" in only the most trivial and evanescent sense.

Alvarez' acceptance of diagnoses will cause some raised eyebrows among psychiatrists who have known and treated some of the persons mentioned in the book; and the choice of materials (and omissions) will seem odd to persons familiar with the field. There are a large number of small inaccuracies, and some whoppers. How it is possible for anyone who has really read the *Autobiography of a Schizophrenic Girl* to have confused (p. 98) the patient (Renée) with her well-known Swiss therapist (Marguerite Sechehaye who is also listed in the "Contents" as a schizophrenic!) is a mystery to this reviewer. Possibly no real confusion but only careless writing is involved here. Some of the blame for the infelicities of this book must rest upon Hervey Cleckley, Alvarez' "introducer." Alvarez is writing outside his field, but Cleckley, who has served as professor of psychiatry at the University of Georgia School of Medicine and is an ex-Rhodes scholar, ought to have been able to straighten out style and English, as well as psychiatric obliquities.

Space and Time. By EMILE BOREL. xvi and 243 pages, including name and general indices, four appendices and 15 figures. Paper. Dover. New York. 1960. Price $1.45.

There can be no higher praise for this book than that, besides its historic interest, it is still of value for fact and the understanding of fact, although it was first published 39 years ago. Problems of space and time are of as much interest to psychiatrist and psychologist today as they were originally to the physicist; and this work is well worth a place in the basic scientific library of either discipline.

CONTRIBUTORS TO THIS ISSUE

HAROLD F. SEARLES, M.D. Dr. Searles, a graduate of Cornell University in 1940 and of the Harvard Medical School in 1943, is a psychoanalyst and a senior staff member at Chestnut Lodge Sanitarium, Rockville, Maryland. He is also a consultant in psychiatry to the National Institute of Mental Health, Bethesda, Maryland. Dr. Searles interned and had an assistant residency in internal medicine at the New York Hospital, then served a psychiatric residency in the Veterans Administration mental hygiene clinic in Washington. After service in the army, he became a staff psychiatrist at the Washington clinic, following residencies at Chestnut Lodge. He is certified in psychiatry by the American Board of Psychiatry and Neurology, has completed psychoanalytic training, and is a member of the Washington Psychoanalytic Society and the American Psychoanalytic Association. He has been an instructor in the Washington Psychoanalytic Institute and a teaching analyst there, and is now a training and supervising analyst. He is a diplomate of the Washington School of Psychiatry and is a fellow of the American Psychiatric Association. He has been a full-time staff member at Chestnut Lodge for a number of years. Dr. Searles is author of a number of psychoanalytic papers.

IRVING I. EDGAR, M.D. Dr. Edgar received his M.D. degree at Wayne State University in 1927 and an M.A. in English Literature in 1933, also at Wayne State University.

He has been a practising psychiatrist in Detroit for many years. He is a diplomate of the American Board of Psychiatry and Neurology. He is a fellow of the American Psychiatric Association and of the American College of Physicians. He is a member of the American Academy of Neurology, the Michigan Society of Neurology and Psychiatry, the Academy of Religion and Mental Health and numerous other medical and psychiatric organizations.

Dr. Edgar was a special lecturer in medical history at Wayne State Medical School for many years.

He is now Assistant Medical Director of St. Clair Psychiatric Hospital of Detroit, and is a consultant psychiatrist for two general hospitals and the Florence Crittenton Maternity Home of Detroit; and he is on the staffs of four other hospitals.

He is the author of numerous publications in various medical and psychiatric journals.

YE. A. POPOV, M.D. Dr. Popov, born in 1899, died in June 1961. He was scientific director of the (Moscow) Scientific Research Institute of Psychiatry. Graduated in 1924 from the Kharhov Medical Institute, he became a member of the Kharhov Scientific Research Institute of Psychiatry, then was professor and head of the department of psychiatry at the Kharhov Medical Institute. He also had served as professor at the Ukrainian Institute of Advanced Training of Physicians and was a member of the Ukrainian Scientific Research Institute of Neuropsychiatry, both at Kharkov. He was director of the first psychiatric clinic there. Dr. Popov was chairman of the psychiatry department and head of the clinic of psychiatry which was dedicated to S. S. Korsakov, at the first Moscow Medical Institute (which was dedicated in I. M. Sechenov) from 1951 to 1959. He became scientific director of the Moscow research institute in 1960. Dr. Popov's areas of research were in the application of Pavlovian psychology to clinical psychiatry and conditioned sleep therapy; the use of chlorpromazine therapy in psychiatric disorders; forensic psychiatry; and the psychological problems of space flight.

DR. EDWARD G. COLBERT, M.D. Dr. Colbert is medical director at the Xavier Psychiatric Clinic, St. John's Hospital, Santa Monica, Calif., and is a research associate in the department of psychiatry, UCLA Medical Center. He was graduated from Marquette University School of Medicine in 1953. He interned at Queen of Angels Hospital, Los Angeles and had residencies at N. Y. U.—Bellevue Medical Center and at UCLA.

RONALD R. KOEGLER, M.D. Dr. Koegler was born in Atlantic City, in 1927. His undergraduate work was done at Stanford University and he received his M.D. from Temple University Medical School in 1953. He interned at the Wadsworth Veterans Administration Hospital in Los Angeles and completed his first two years of psychiatric residency at Metropolitan State Hospital in Norwalk, Calif. His residency training was completed at UCLA, and was followed by a year as chief psychiatric resident for the UCLA Neuropsychiatric Institute. Since 1958, Dr. Koegler has been a research psychiatrist at UCLA and is now assistant professor of psychiatry in the UCLA School of Medicine.

ROBERT HIRSCH, M.D. Dr. Hirsch, born in New York City in 1926, received a B.S. degree from Lynchburg College (Va.) in 1949, a master's degree in psychology from Fordham University in 1950 and an M.D. from New York Medical College in 1954. After interning in Flushing Hospital

in New York City, Dr. Hirsch became affiliated with Bellevue Hospital, the New York Veterans Administration, the Albert Einstein Medical Center, and Riverside Hospital for his psychiatric training. He currently is engaged in private practice on Long Island; he is a candidate in the comprehensive course in psychoanalysis at the New York Medical College, and he is also a consultant to the Jewish Community Services of Long Island, where his interests involve geriatric and adolescent problems.

RICHARD D. CHESSICK, M.D. Dr. Chessick is chief of the psychiatry service at the Veterans Administration Research Hospital in Chicago. He received his M.D. from the University of Chicago and served his residency in psychiatry at the University of Illinois. He spent two years at the U. S. Public Health Service Hospital, Lexington, Ky. He is certified in psychiatry and is associate in psychiatry at Northwestern University Medical School. He is a member of the American Psychiatric Association, the American Academy of Psychotherapists, the American Psychosomatic Society, Sigma Xi, and the American Association for the Advancement of Science. He has written a number of articles on neurologic and psychiatric research. He is married and has two children.

W. W. MEISSNER, S.J. Father Meissner is a Jesuit priest with a graduate degree in psychology from St. Louis University. He is now a research associate on the staff of Woodstock College. He has written frequently for psychological journals, including the *Journal of Abnormal and Social Psychology*, the *Psychological Review* and the *Journal of General Psychology*. He is also on the abstracting staff of *Psychological Abstracts*.

MAURICE R. GREEN, M.D. Dr. Green is a graduate of the College of Liberal Arts, Northwestern University, where he made Phi Beta Kappa, and he was graduated from the Medical School at Northwestern in 1945. He served a one-year rotating internship before induction into the army in 1946, where he became a neuropsychiatrist, then chief of neuropsychiatry. In 1948, he was a resident in neuropsychiatry at the Bronx Veterans Administration Hospital. He had postgraduate training at the William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, receiving a certificate in psychoanalysis in 1954.

Dr. Green has been psychiatrist of the Low Cost Psychoanalytic Service of the White Institute; has been clinical assistant in child psychiatry, then assistant attending, and attending, at Roosevelt Hospital, New York; has served at the Child Guidance Clinic of the Jewish Board of Guardians;

has been on the board of advisors of the Institute of Jazz Studies; and has been consulting psychiatrist at Brookwood Hall, East Islip, N. Y. He has been with the Bleuler Psychotherapy Center, Jamaica, N. Y., since 1956; is staff psychiatrist at the psychiatric clinic, Court of Special Sessions, New York City; and is on the board of advisors, Spring Lake Ranch, Cuttingsville, Vt. He is in private practice in New York City and is an instructor on the faculty of the William Alanson White Institute.

Dr. Green has had papers published in THE PSYCHIATRIC QUARTERLY and other scientific journals. He wrote a chapter on Martin Buber for *The American Handbook of Psychiatry*, and recently was co-author of *Prelogical Experience*, with Dr. Edward S. Tauber.

Dr. Green is a diplomate in psychiatry of the American Board of Psychiatry and Neurology; a fellow of the American Psychiatric Association and the Academy of Psychoanalysis; and a member of the New York State Medical Society, the William Alanson White Psychoanalytic Society, the Association for the Psychiatric Treatment of Offenders, the New York Academy of Sciences, the American Orthopsychiatric Association, the American Association for the Advancement of Science, and the World Federation for Mental Health.

DAVID LANDY, Ph.D. Dr. Landy is associate professor of anthropology in the Graduate School of Public Health and in the Department of Anthropology, at the University of Pittsburgh, where he is directing a program in teaching and research in the social sciences in the fields of public health. He is also director of a research project dealing with relations between the meaning of work and the development of emotional illness, sponsored by the Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare and the University of Pittsburgh's Graduate School of Public Health. Formerly he was co-principal investigator of the project on rehabilitation of the mentally ill, Massachusetts Mental Health Center, Boston; research associate in anthropology, Harvard Medical School; and lecturer and research associate at the School of Social Work, Boston University.

Dr. Landy is author of *Tropical Childhood* (University of North Carolina Press, 1959); numerous papers in anthropology and in psychiatric rehabilitation research, and co-author of a forthcoming book, *Halfway House, A Sociocultural and Clinical Study of Rutland Corner House, a Transitional After-Care Residence for Female Psychiatric Patients* (University of Pittsburgh Press).

DONALD A. SCHWARTZ, M.D. Dr. Schwartz, born in Brooklyn in 1926, took pre-medical studies at the University of Michigan from 1942 to 1944. After a summer session at the University of Southern California

in 1944, he went into the army where he served with the medical detachment of the 127th Infantry Regiment and later was sergeant in charge of the 25th Division Clearing Company Hospital in the Pacific theater of operations. He completed his medical training at the University of Michigan and the University of Southern California in 1947 and 1948 and obtained his medical degree from the School of Medicine of Western Reserve University in 1952.

Dr. Schwartz is now chief of in-patient services at the Neuropsychiatric Institute of the University of California Medical Center in Los Angeles, and is assistant professor of psychiatry at UCLA. He interned at the Cedars of Lebanon Hospital in Los Angeles, served as a resident at the Langley Porter Clinic, San Francisco, served at Patton and Pacific (Calif.) state hospitals and as a resident at the Neuropsychiatric Institute where he is now a staff member. He held various positions there before he became chief of the psychiatric in-patient service in 1959. Dr. Schwartz is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and a member of various other professional organizations. He is the author of a number of published scientific articles. Dr. Schwartz is married and has two children.

NEWS NOTES

NEW N. Y. INSTITUTIONS FOR DEFECTIVES STARTED

Plans for a $17,000,000 school for the mentally retarded in upstate New York and for a similar $35,000,000 institution on Long Island to serve the metropolitan area have been announced by the New York State Department of Mental Hygiene. The upstate site is at Mt. McGregor in Saratoga County where buildings formerly used by the Veterans Administration are being remodeled. They can now accommodate 130 patients and are being enlarged to take in another 215. New construction to be undertaken at once will house 1,180 patients.

The Long Island school in Huntington will be large enough for 2,876 patients. Work on the first building, a $1,500,000 power house, is expected to be under way there by spring. Both new institutions are designed on a modified cottage plan. Children likely to benefit from education and training will be housed in 30-bed cottages. Other units will be constructed for severely retarded and adult patients. These will house from 60 to 130 patients each, with wards of 30 to 40 patients. Each institution will have a medical-surgical building.

New York State has reported reductions in resident patients in its mental hospitals in recent years; but the population of the state institutions for mental defectives has continued to grow.

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HARRY C. STORRS, M.D., DIES IN NEW HAMPSHIRE

Harry C. Storrs, M.D., head of Letchworth Village (Thiells, N.Y.) from 1937 until his retirement as senior director five years ago, died in Rumney, N. H., while visiting friends there on August 25, 1961. He had been living in Hanover, N. H., since his retirement. Dr. Storrs was superintendent of Wassaic (N.Y.) State School before being named to head Letchworth Village as successor to Dr. Charles S. Little. In all, he served the mentally retarded for some 40 years. He was a former president of the American Association of Mental Deficiency.

Dr. Storrs was a graduate of Dartmouth College and of Dartmouth Medical School. His survivors include two sons, Dr. Robert C. Storrs of Hanover, N. H., and Dr. Richard Storrs of Los Angeles, and seven grandchildren.

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CENTER OF ALCOHOL STUDIES MOVING TO RUTGERS

The Center of Alcohol Studies which has been located at Yale University since 1921, is being transferred to Rutgers, The State University (of New Jersey) at New Brunswick, N. J. The center has been active in re-

search; it conducts a nationally-known summer school of alcohol studies which will be at Rutgers in 1962 and publishes the *Quarterly Journal of Studies on Alcohol*, besides books and other material. All these activities will be conducted at Rutgers under virtually the same personnel as at Yale. Selden D. Bacon, Ph.D., director of the center and professor of sociology, and Dr. Leon A. Greenberg, director of the Laboratory of Applied Biodynamics and associate professor of applied biodynamics, will transfer from the Yale to the Rutgers faculty.

Dr. Mason W. Gross, president of Rutgers, has announced that the transfer of the center is made possible by a grant from the National Institute of Mental Health. The grant will cover the cost of the transfer and most of the operating costs for the next six years.

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MARY C. JARRETT DIES AT 85

Miss Mary C. Jarrett, who was known for many years as the "mother" of psychiatric social work, died on August 4, 1961 in New York City. Miss Jarrett, born in Baltimore and a graduate of Goucher College, began her psychiatric social work with the Boston Children's Aid Society and the Boston Psychopathic Hospital, where she organized the social service department and became its chief in 1913. Miss Jarrett was active during the past 30 years in community programs for the chronically ill. She had retired from active work several years ago but continued to act as a consultant.

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GRANT AIDS J. O. B. EMPLOYMENT RESEARCH

Just One Break, Inc. announces receipt of a federal grant to finance research—now under way for a year—in a study of finding work for former mental patients. The organization is a placement agency, formerly specializing in the placement of physically disabled persons in competitive industry. Its present research effort is to find means to eliminate the stigma and misconceptions surrounding former mental patients, and so increase their employability. It is using psychological and vocational evaluations in sending such former patients to co-operating companies, and Myrtle L. Vogelson, director of the study, reports that results so far have been encouraging.

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HOFHEIMER PRIZE CLOSING DATE ANNOUNCED

The closing date for entries for the 1962 Hofheimer Prize of $1,500 is announced by the American Psychiatric Association committee in charge of the prize as March 2, 1962. The award is granted annually for the best published contribution in psychiatric or mental health research by

a worker of 40 years of age or less to be made by an American or Canadian citizen within three years of the granting of the award at the American Psychiatric Association annual meeting. The age is as of the time the paper was submitted for publication; and research groups of a median age of 40 or less are eligible.

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MUSIC CENTER ISSUES PROGRESS REPORT

A progress report showing a total of 107 mental patients referred for therapy, 29 of them in the year ended August 31, 1961, has been issued by the Music Rehabilitation Center of the Musicians Emergency Fund. The report shows that 29 psychiatric out-patient clinics and hospitals and 21 private psychiatrists have referred patients there for music therapy.

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MEDICAL RESEARCH SOCIETY MOVES HEADQUARTERS

The National Society for Medical Research announces removal of its headquarters from Chicago to 111 Fourth Street, S.E., Rochester, Minn. The move is to be near the society's new president, Dr. Hiram E. Essex, emeritus professor of physiology of the Mayo Foundation.

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FRANCE DECORATES NEW YORK RESEARCH DIRECTOR

Herman C. B. Denber, M.D., director of psychiatric research at Manhattan (N.Y.) State Hospital, has been decorated by the French government in recognition of his work in increasing scientific and cultural exchanges between French and American psychiatrists. He was made a *Chevalier de l'Ordre de la Santé* at a ceremony in the Ministry of Health in Paris.

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NAMH DISTRIBUTES NEW BLONDIE BOOKLETS

The National Association of Mental Health has announced that it is now distributing the revised "Blondie" mental health book, produced by co-operation of King Features and the New York State Department of Mental Hygiene, on a nationwide basis. In the new edition, the children are older, the Bumsteads have a refrigerator with a big freezer, and Blondie wears up-to-date clothes.

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MEETINGS AND COURSES ARE ANNOUNCED

Professional society activities in psychiatry and related fields will be highlighted by the annual meetings of the American Psychiatric Association and seven other professional organizations in Toronto early in May.

The American Psychiatric Association will meet in Toronto May 7-11, as will the Association of Mental Hospital Chaplains. The Society of Biological Psychiatry will meet there May 4-6; the American Psychoanalytic Association, May 4-7; The Academy of Psychoanalysis, May 5 and 6; and the Academy of Psychodrama and Group Psychotherapy, the American Academy of Child Psychiatry, and the American Society of Medical Psychiatry, on May 6.

The American Association on Mental Deficiency will also conduct its annual meeting in May. It will be in New York City, May 1 through May 5. The American Orthopsychiatric Association will have its annual meeting March 21-24, in Los Angeles, the first time the association has met in that city.

The National Association of Private Psychiatric Hospitals will hold its annual meeting January 22-24 in Sarasota, Fla.

The annual meeting of the American Psychosomatic Society will be in Rochester, N. Y., March 30-April 1, and the annual meeting of the Academy of Religion and Mental Health will be in New York City, April 25-27.

The psychiatric section of the National Association of Social Workers will have its annual institute on May 26 in New York City.

The Mental Hospital Institute of the American Psychiatric Association will be conducted in Miami Beach, September 24-27.

International meetings of interest to psychiatrists include the World Health Assembly of the World Health Organization in Geneva, Switzerland, May 3-21. An international conference on health and health education under the auspices of the International Union for Health Education in collaboration with the World Health Organization will be held in Philadelphia June 30-July 7. The Summer School of Alcohol Studies, conducted annually at Yale since 1943, will be held at Rutgers University, New Brunswick, N. J., July 1-26. The school has been transferred permanently to Rutgers.

Also of interest to psychiatrists are a number of meetings and lectures scheduled for late in 1961. They include the Sixth Annual Conference on Failure in Psychotherapy of the American Academy of Psychotherapists in New York City on October 14-15; a symposium on psychoanalysis in honor of the seventieth birthday of Franz Alexander on November 10-11 in Los Angeles; the eleventh annual meeting of the Association for Mental Health at Miami Beach, November 15-18; the sixth Hahnemann Symposium on Psychosomatic Medicine in Philadelphia, December 10-14; the annual Salmon lectures at the New York Academy of Medicine, December 4; a midwinter meeting of the Academy of Psychoanalysis, December 9-10; and a series of workshops and scientific meetings of the Eastern Group Psychotherapy Society at the New York Academy of Sciences, from October 27, 1961 through April 20, 1962.

BACK NUMBERS WANTED

Copies of a number of back issues of THE PSYCHIATRIC QUARTERLY and SUPPLEMENT are needed to complete sets.

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